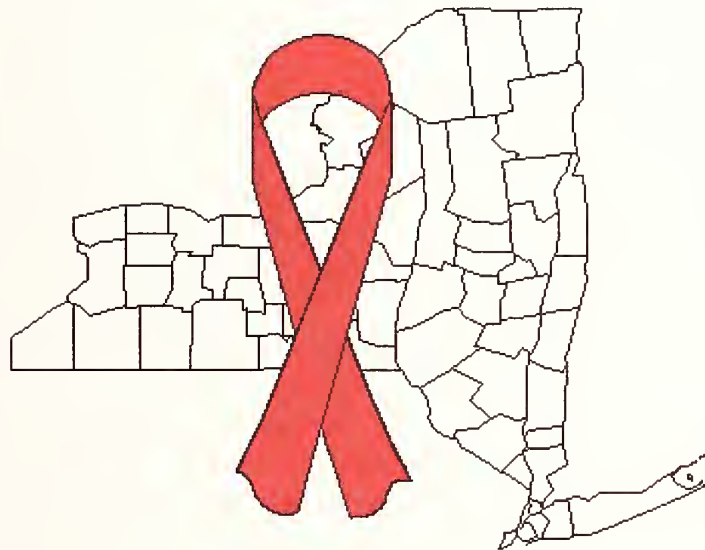


HIV/AIDS

Epidemiologic Profile

New York State

2005-2006



Prepared for the
New York State HIV Prevention Planning Group
by the
Division of HIV Prevention
AIDS Institute
New York State Department of Health

Volume 1 of 2



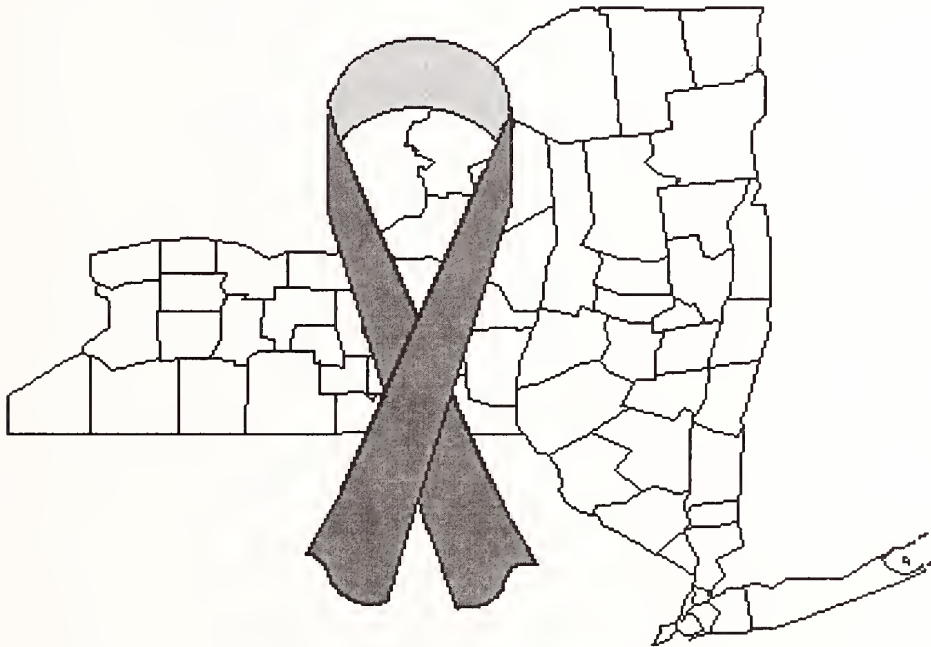
Office of Minority Health Resource Center
Knowledge Center
1101 Wootton Parkway
Rockville, MD 20852
1-800-444-6472

HIV/AIDS

Epidemiologic Profile

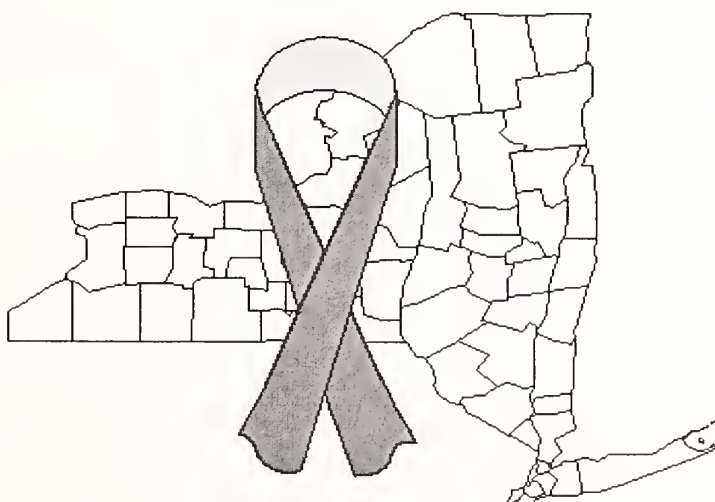
New York State

2005-2006



Prepared for the
New York State HIV Prevention Planning Group
by the
Division of HIV Prevention
AIDS Institute
New York State Department of Health

Volume 1





Dedication

The moment of completion of the *Epidemiologic Profile* is always bittersweet. The difficult task of tracing and describing the history of HIV/AIDS in New York State up to the present moment is finished; the future is yet to be known. There are, of course, some very safe predictions that can be made: researchers will continue to elucidate the workings of the virus; new medications will go into clinical trial or become available for use; those working in health care will work to improve the quality and quantity of their patients' lives; statisticians will continue to count cases, prevention researchers and educators will continue to look for that perfect moment when behavior change occurs and another life is saved, and, as much as we might wish it not to be so, there will be loss, grief, and pain.

These recent months have brought us an expanded -- and very global -- understanding of loss. The tsunami washed away people, families, towns and cultures. Lives are lost throughout the world wherever armed conflict or famine or subjugation or disaster occur. We all live our daily routines knowing that a sub-Saharan community in which 30% of its young people are HIV-infected is a community that will, in time, lose a generation. Now New Orleans and the Gulf Coast are reeling from Katrina and floodwaters while Baghdad mourns the hundreds who fell to their deaths or were trampled during a pilgrimage. This is truly the bitter.

And the sweet? It, too, resides in the very same events: the tourists in Thailand who stayed on to work in makeshift hospitals, the famine relief workers in Niger feeding one hungry child after another, the convoy of sports fishermen and women who brought their flat-bottomed boats to New Orleans to rescue folks from the flooding, and the Laotian monk single-handedly running an AIDS hospice on the outskirts of Vientienne.

This edition of the *Epidemiologic Profile* is dedicated to the sweet: to the good in every occurrence no matter how devastating, to those with HIV-infection and those who love and care for them, to all who were lost this year and to all of us who lost them, to all whose lives may be cut short by future ill or catastrophe and to all those who will manage to make even the shortest life a sweet life.



Acknowledgements and Thanks

This edition of the Epidemiologic Profile is quite different than its predecessors and represents the combined efforts of many more people than have historically contributed. The contents are the work of NYS Department of Health staff from both the AIDS Institute and the Center for Community Health as well as researchers and service providers throughout NYS and beyond. As always, support and input from the community adds to the quality and usefulness of this document.

Gratitude is too small a word to express to the following individuals and groups our thanks for their participation. They are:

Susan J. Klein and Wendy Shotsky, recently “retired” from the NYS HIV Prevention Planning Group but continuing their AIDS Institute prevention work, for their input and editing ***** Donna Glebatis and Lou Smith along with the staff of the Bureau of HIV/AIDS Epidemiology (BHAEE) for guidance and for data preparation ***** Ling Wang, Christopher Nemeth, and Wendy Pulver, all of BHAEE, for data and editing of research and seroprevalence activities ***** Bruce Coles, Todd Gerber, Alba Di Carlo, and staff of the Bureau of Sexually Transmitted Disease Control for STD data ***** William Karchner for his help in understanding the impact of HIV/AIDS stigma ***** Mara San Antonio-Gaddy and April Richardson-Moore for counseling and testing data ***** Marilyn Kacica and staff of the Regional Epidemiology/Infection Control Program for Hepatitis data ***** Margaret Oxtoby and the Bureau of Tuberculosis Control staff for data on tuberculosis ***** Roberta Glaros for her help with Comprehensive Newborn Screening Program outcomes ***** The membership of the NYS HIV Prevention Planning Group for inspiration, guidance, and editing of the final draft

And to Dan O’Connell and Bethsabet Justiniano, Division of HIV Prevention, for their exceptional wisdom, humor, input, editing, support and guidance in all things preventive.



Volume 1

Table of Contents

Dedication	i
Acknowledgements	iii
Table of Contents	v
Introduction to the 2005-2006 Epidemiologic Profile	xiii
Visual Display of Racial/Ethnic Data: Data Availability Notice	xv
 Question 1: What are the sociodemographic characteristics of the general population in New York State?	 1-1
Introduction	1-3
New York State Demographics and Geography	1-5
Key Geographical Markers and Locales in NYS	1-6
Major Urban Centers	1-7
New York State and Major Urban Centers by Race/Ethnicity	1-7
Census 2000 Populations for Boroughs and Counties of NYS	1-8
Rural, Suburban, and Urban Population Distribution	1-9
Northeast Corridor	1-9

Native American Nations, Territories, Reservations, and Villages	1-10
Native American and Alaskan Natives in NYS by Place of Residence	1-11
Native American/Alaskan Native Population in New York State by County	1-12
Vital Statistics in NYS	1-13
A Day in the Life of New York State	1-13
New York State Population by Age Group	1-14
Poverty Level and Median Household Income	1-14
New York State by Federal Poverty Level	1-15
Poverty Level by Age and Family Status in NYS	1-16
Boroughs and Counties of NYS by Estimated Number and Percent of Residents Living in Poverty	1-17
Federal Poverty Level by Age Group	1-18
Federal Poverty Level by Race/Ethnicity	1-19
The Foreign-born in NYS	1-19
Foreign-Born 5 Years of Age and Older Residing in NYS by Region of Birth	1-20
Languages Spoken at Home in NYS	1-20
Educational Attainment	1-21
Health Insurance Coverage	1-22
NYS Population by Insurance Status	1-22
Distribution of Nonelderly Uninsured by Federal Poverty Level	1-23
Distribution of Nonelderly Uninsured in NYS by Race/Ethnicity	1-24
References for Question 1	1-26

Question 2: What is the scope of the HIV/AIDS epidemic in New York State?	2-1
Introduction	2-3
Data Notes	2-5
Data Issue: The Growth of “Other/NIR/NRR”	2-7
CDC Transmission Category Hierarchy	2-8
New York State HIV/AIDS Surveillance Semiannual Report – June 30, 2004	2-11
Graphic Display of NYS Descriptive Data	2-43
2004 Epidemiologic Profile of New York State by Geography, Ryan White Region, and New York City Borough	2-37
New York State	2-45
New York City	2-49
Borough of the Bronx	2-53
Borough of Brooklyn	2-57
Borough of Manhattan	2-61
Borough of Queens	2-65
Borough of Staten Island	2-69
New York State Excluding New York City (Upstate NY)	2-73
Albany (Northeast, Capital) Ryan White Region	2-77
Binghamton Ryan White Region	2-81
Buffalo Ryan White Region	2-85
Lower Hudson Ryan White Region	2-89
Mid-Hudson Ryan White Region	2-93
Nassau/Suffolk Ryan White Region	2-97
Rochester Ryan White Region	2-101
Syracuse Ryan White Region	2-105

Data Interpretation: Examples for Use with Question 2 Data and Materials	2-109
Data Further Describing New York	2-117
NYS AIDS Cases by Transmission Category, Year of Diagnosis: Ryan White Regions and Boroughs of New York City – 1993 to 2003	2-119
Cumulative Adult AIDS Cases in NYS by Race/ Ethnicity, Age at Diagnosis, Gender, and Risk Data through 2003	2-136
Cumulative Adult AIDS Cases in NYS by Race/ Ethnicity, Age at Diagnosis, Gender, and Risk Data through 2003	2-137
Cumulative Adult AIDS Cases in NYS excluding NYC (Upstate NY) by Race/Ethnicity, Age at Diagnosis, Gender, and Risk - Data through 2003	2-138
Cumulative Adult HIV Cases in NYS by Race/ Ethnicity, Age at Diagnosis, Gender, and Risk Data through 2003	2-139
Cumulative Adult HIV Cases in NYC by Race/ Ethnicity, Age at Diagnosis, Gender, and Risk Data through 2003	2-140
Cumulative Adult HIV Cases in NYS excluding NYC (Upstate NY) by Race/Ethnicity, Age at Diagnosis, Gender, and Risk - Data through 2003	2-141
NYS Adult AIDS Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-142
NYC Adult AIDS Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-143
NYS (excluding NYC) Adult AIDS Cases Diagnosed in 2002-2003 by Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-144
NYS Adult HIV Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-145
NYC Adult HIV Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-146
NYS (excluding NYC) Adult HIV Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-147

AIDS Cases among Adults/Adolescents Ages 13-24 Diagnosed 2000-2003 by Age at Diagnosis and Transmission Category	2-148
Cumulative NYS AIDS Cases Among Adult Males Ages 25+ by Year of diagnosis and Race/Ethnicity	2-151
Cumulative NYS AIDS Cases Among Adult Females Ages 25+ by Year of diagnosis and Race/Ethnicity	2-153
NYS Persons 50+ Years of Age Living with HIV/AIDS by Gender, Race/Ethnicity, Age at Diagnosis, and Geographic Region	2-155
NYS AIDS Cases Diagnosed 2000-2003 Among Persons 50+ Years of Age by Gender, Race/Ethnicity, Age at Diagnosis, and Geographic Region	2-156
Persons Living with HIV/AIDS by Age, Transmission Category, and Race/ Ethnicity: NYC and Upstate NY	2-157
AIDS Cases Diagnoses During 2002 and 2003 per 100,000 Population by Race/ Ethnicity and Ryan White Region	2-159
Adults Living with HIV/AIDS by Race/ Ethnicity, Age at Diagnosis, Gender and Risk: NYS, NYC, and NYS (excluding NYC)	2-162
Pediatric AIDS Cases by Gender, Age at Diagnosis, Race/Ethnicity, and Mother's Transmission Risk – 2000-2003	2-165
Pediatric AIDS Cases Diagnosed 2000-2003 by Race/Ethnicity, Exposure Category, Age at Diagnosis, Rate per 100,000 Population and NYS Geographic Region	2-167
Perinatally-Infected Persons Living with HIV/AIDS by Race/Ethnicity, Gender, and New York State Region	2-168
Further Data Describing NYS	2-169
New York State and Counties as Compared to the District of Columbia and other States (A Ranking)	2-171
Counseling and Testing	2-179
AIDS as a Leading Cause of Death/AIDS Mortality	2-187

Volume 2

Table of Contents

Dedication	i
Acknowledgements	iii
Table of Contents	v
Introduction to the 2005-2006 Epidemiologic Profile	xiii
Visual Display of Racial/Ethnic Data: Data Availability Notice	xv

Continued from Volume I

Youth Risk Behavior Surveillance System YRBSS)	2-193
New HIV/AIDS Surveillance Activities	2-197
Statistical Abstract – 2003, Sexually Transmitted Disease Control Program, NYSDOH	2-199
Eliminating Syphilis -- New York	2-239
HIV Epidemiology Program: 1 st Quarter 2006 Report New York City Department of Health and Mental Hygiene – Data through March 31, 2005	2-241
Question 3: What are the indicators of risk for HIV infection and AIDS in New York State?	3-1
Introduction	3-3
External Factors	3-5
Poverty	3-7
Trauma	3-11

Rural Life	3-13
Stigma	3-19
Key Populations of NYS	3-21
Men who have Sex with Men	3-23
Injection Drug Users	3-33
Heterosexuals	3-39
Mother-to-Child-Transmission: Pregnant Women and Newborn Children	3-43
Persons at Particular Risk	3-49
Introduction	3-51
Inmates	3-53
Individuals with One or More Disabilities	3-59
Mentally Ill Chemical Abusers (MICA)	3-67
Individuals who are Homeless	3-69
Housing: Top 10 Least Affordable States	3-72
What does it take to <i>not</i> be homeless?	3-72
Immigrants	3-73
Migrants and Seasonal Workers	3-75
Persons of Transgender Experience	3-79
Alcohol and Non-injection Drug Use	3-91
Drug and Alcohol Use and Perception of Risk of Abuse: Persons 12 Years of Age and Older	3-92
Young People	3-97
Direct and Indirect Marker of HIV Risk	3-99
The Importance of Certain Communicable Diseases when in Conjunction with HIV	3-101

Selected Communicable Diseases: A Brief Description	3-102
Primary and Secondary Syphilis, Gonorrhea, and Chlamydia	3-105
Selected Communicable Diseases of Concern in HIV/AIDS Prevention by NYS Geographical Region And County	3-111
Trends in Selected Communicable Diseases by Geographical Distribution	3-113
Tuberculosis in New York State	3-115
Cervical Cancer	3-119
Pregnancy-Related Data	3-125
Geographic Risk	3-127
Out-of-State Risk	3-127
Drug Transport Routes:	3-129 3-132/3
Commercial Sex Work	3-135

Appendices	a-1
Abbreviations and Acronyms	a-3
Key Data Sources	a-5
How to Read and Understand a Scientific or Epidemiologic Article	a-7
NYS HIV Prevention Planning Group Epidemiologic Manual	a-13
Contact and Ordering Information	a-27



Introduction to the 2005-2006 Epidemiologic Profile

The AIDS epidemic in New York State is as diverse and fluid as are the people who reside here. Some neighborhoods are experiencing their third decade of HIV; others are experiencing living with or have in their social networks, people living with HIV/AIDS for the first or second time. Older New Yorkers are learning that AIDS is not simply a concern of young adults at the same time that a generation of infants born with HIV infection are now young people living with HIV/AIDS and making decisions about their own relationships and children. In the early 1980s prevention workers struggled against injection-related HIV transmission; now, in the 14th year of legal syringe exchange and 5th year of ESAP (Expanded Syringe Access Program) recent research has shown that currently injectors are more likely to become infected through high risk sexual activity than through safer injection practices. In the early development of prevention programs, tailoring an intervention meant altering Gay Men's programming to serve heterosexual women. Now program tailoring is the delicate science of adapting interventions proven successful with one risk constituency to another that differs by age, geography, race/ethnicity, gender, transmission risk, language, literacy, and/or any of a myriad of other crucial factors.

This fluctuation is neither unidirectional nor takes place at a steady pace. Breakthroughs in understanding, whether science-, program-, or care-related occur without pattern or calendar. Set-backs occur with loss of political will, in acts of stigmatization, and, indirectly, through competing needs for funding, resources, and attention.

Every year the task of describing the epidemic in New York State grows more complex. In the past, AIDS case data was the primary tool for description of the present and projection of the future. Today's tools include HIV testing outcomes, STARHS* testing to determine recentness of seroconversion, and new methods and assays** for identifying acute HIV infection *during* the acute -- and more transmissible -- phase.

For the readers of the Epidemiologic Profile it has always been extremely important to study the data carefully and to be very sure that the source, quality, and quantity of the data is reasonable – and understood. With this edition, it also becomes important to merge a general understanding of life as lived by New Yorkers with knowledge of HIV

prevention intention, programming, and dissemination. The Centers for Disease Control and Prevention now urges all jurisdictions to adopt a more inclusive format wherein the current state of the epidemic, i.e. “the numbers”, is flanked by the descriptors of the general public on one side and the details of vulnerability to HIV infection and transmission on the other.

Ideally, this publication will be a ready source of background material, of data, and of prevention concerns for all those who struggle to end the HIV epidemic. The primary goal is to inform. Why be informed? Reduced to the simplest terms, it is only by understanding what has taken place up to this point in time and what is taking place today that we can, together, address, contain, and obliterate -- the future of the HIV/AIDS Epidemic.

- * STARHS is the acronym for *Serologic Testing Algorithm for Recent HIV Seroconversion* also known as the detuned assay. A newer version of this assay is called the BED-assay, a name referring to the B,D, and E clades (strains) of HIV it was designed to detect.
- ** A new qualitative (yes/no or positive/negative outcome) plasma RNA test. The current plasma RNA tests are quantitative, meaning that the amount of RNA is being measured rather than the presence or absence of RNA.

Visual Display of Racial/Ethnic Data Data Availability Notice

The Membership of the NYS HIV Prevention Planning Group wishes to raise the issue of use of the term "other" in display or description of racial and ethnic-related data in HIV/AIDS publications, epidemiology, health services research, demographics, or in any situation where populations and subpopulations are described. The PPG, and others, believe that "other," when as a racial/ethnic category, is problematic. The absence of sub-population or sub-group data describing the impact of the HIV/AIDS epidemic:

- [1] Allows affected communities to ignore and/or deny the presence of and needs of HIV-infected individuals in their midst
- [2] Contributes to the stigma of the disease by making invisible those living with or dead from the disease
- [3] Denies health care and service providers access to vital planning and service delivery information
- [4] Unnecessarily limits the general public's understanding of the scope and nature of the epidemic
- [5] Contributes to the isolation of the affected and infected individual, relationship, family, and community

At *minimum*, the ideal data categorization array would be:

White (not Hispanic)
Black (not Hispanic)
Hispanic or Latino (all races)
Asian and Pacific Islander (including Native Hawaiians)
Native American and Alaskan Native
2+ Races (all persons of two or more races)
Other, Unknown Race/Ethnicity*

*True 'other' [example: Australian Aboriginal] and those for whom no data exists or was reported

If, for reasons of confidentiality/small cell size and/or incomplete/irregular reporting, two or more categories must be collapsed, the full name of the groups involved are listed and data totals are included where possible.

The problem arises, typically but not always, when using data from sources other than BHAE/NYSDOH or CDC HIV/AIDS Surveillance publications. For example, published and readily available national demographic data and descriptive data from the research literature are often broken down into only four categories: White, Black, Hispanic, and Other.

The NYS HIV Prevention Planning Group urges that inclusive demographic categorization become the norm. Further, in situations where the full array cannot be utilized for reasons of confidentiality and/or other valid conditions, the PPG membership suggests the truncated data be accompanied by a ***Data Availability Notice*** that includes [1] justification/explanation for truncation and [2] a total count of the censored/omitted data.

Question 1:

What are the sociodemographic characteristics of the general population in New York State?



Introduction

To better conduct HIV prevention, it is necessary and important to understand the many factors that can lead to risk and infection. Individuals, couples, families, friendship networks, and communities are or can become vulnerable to infection when unable to access and utilize, among other basic human needs, income, housing, medical and mental health care, education, recreation, and sociocultural support. Some vulnerabilities lead to activities and/or behaviors that can increase the risk of HIV infection; others impede institutions and communities in better protecting their constituencies.

Subsequent sections of this document will, first, answer questions concerning the extent of the epidemic in NYS and, second, the HIV prevention needs of those at risk of infection and those who are living with HIV/AIDS.

This section, "What are the sociodemographic characteristics of the general population in New York State?" begins to describe the people that reside within NYS bounds and, particularly, the vulnerable among them. While the material is not directly HIV-related, its effects are. Following is an example, in this case, relating to geography:

Typically, geography is considered in terms of recreation and scenery, route and time to school and work, and proximity to family and friends. As often as not, geography becomes an occasional, if not constant barrier to care for the individual at risk of or living with HIV/AIDS. An individual with a personal vehicle may reside on one side of the Hudson River while his/her regional AIDS service center and care site are located on the opposite side. Driving North to the nearest bridge then South to the service agency can add twenty miles each way to the round trip as compared to the distance as measured on a map, i.e. a route without a geographic barrier. That extra 40 miles, at the current gas price of \$2.25/gallon, can add \$3.00 to \$4.00 dollars -- and up to an hour's time -- to the cost of the trip. The bridge toll can add another \$3.00 to \$5.00 per round trip. For the individual with weekly visits, this can mean an additional "geographic surcharge" above basic transportation costs of \$200.00 to \$300.00 per year. The individual may not have an income that can absorb the additional cost, or even the base cost. In NYS, of the over 8 million workers ages 16 and older, only 66% own a vehicle or carpool with someone who does. Just over 24% use public transportation. The remainder do not have access to personal or public transportation or are unable to drive their own vehicle. Both personal vehicles and public transportation are vulnerable to weather (snow and ice, flooding, etc) and other disruptive events (bridge replacement, road construction, EZPass [NYS charge card program for tolls], etc.).

The alternatives? There is limited rural public transportation; few family members or friends can be absent from home or work so frequently or for such lengthy periods of time. The individual's needs may not qualify for home nursing or other home visits or his/her agency may not have sufficient trained staff to offer home visits. Further, the individual's home may not be suitable for home visits due to lack of privacy; home health visits and/or transportation services may identify the individual as infected or ill to his/her neighbors.

A similar vignette can be identified for each of the topics discussed in this section: the extremes of population density each present barriers; race/ethnicity differences and income gaps continue to affect access and to divide some of our communities; education may not always be the key to success but lack of education is almost always a barrier to gaining the benefits of a community. Any comprehensive discussion of health and well-being is incomplete without a discussion of access to insurance coverage, particularly in the US where universal coverage is absent. Often it is not the simple story of the haves vs. the have-nots; far more frequently it is the 'have-a-littles' and the 'have-nones' trying to overcome the very barriers that go virtually unnoticed by everyone else.

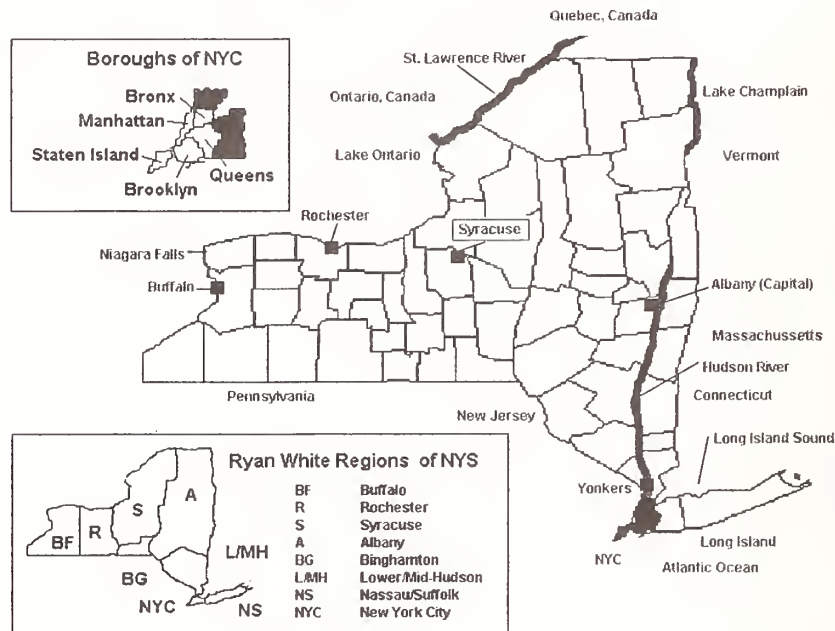
New York State Demographics and Geography

New York State, at 54,475 square miles, is a complex terrain in which over 19 million people reside. Every geographic descriptor applied to the state is stretched to extremes. For example, population density ranges from 3 people per square mile in Hamilton county to 54,900 people per square mile on the island of Manhattan in New York City. NYS is the 3rd largest state by population. While a relatively mid-sized state that by number of square miles ranks 27th in the US, its East-to-West length rivals some of the largest states in the Western US; transiting North-to-South requires 7 hours of Interstate Highway driving. NY is also the only state that reaches border-to-border, from Quebec and Ontario, Canada, to the Atlantic coast, setting the New England states off from the remainder of the continental US.

This geographic positioning has determined much of the state's history. The Hudson and Mohawk Rivers complex was the only break in the Appalachian Mountain chain until the discovery of the Cumberland Gap. Through this break passed all the commerce, settlers, and travelers in the early colonies and the new country except for that which circumnavigated South America by ship. The two river valleys, the Great Lakes shorelines, and abundant waterpower led to the industrialization of the Upstate commerce centers just as the NYC harbor and sea access fueled the growth of New York City.

This key location in North America has also fueled the diversity of NYS: the early permanent European settlers included the Dutch, English, and the French who joined the Iroquois Confederacy and numerous other Native peoples. Many others came to explore and travel. This pull is felt as strongly today as ever: a single square mile in Queens, a borough of New York City, is recognized as racially and ethnically the most diverse place on earth.

Key Geographical Markers and Locales of New York State



New York State borders Ontario and Quebec, Canada, Vermont, Massachusetts, Connecticut, New Jersey, Pennsylvania, and Rhode Island. Both Lakes Ontario and Erie form state borders as do Lake Champlain, the Niagara and Delaware Rivers, Long Island Sound, and the Atlantic Ocean. The Adirondacks, Catskill Mountains, the many smaller ranges, the Finger Lakes, and the many rivers and streams offer recreation and habitat. While the source of much of the state's attraction, these geographic wonders can, in winter snow and summer flooding, make work and travel very difficult. For example, in June, 2005, Interstate 87, the primary North/South corridor from NYC to Montreal was closed in both directions due mud and rock slides from excessive rain and flash floods.

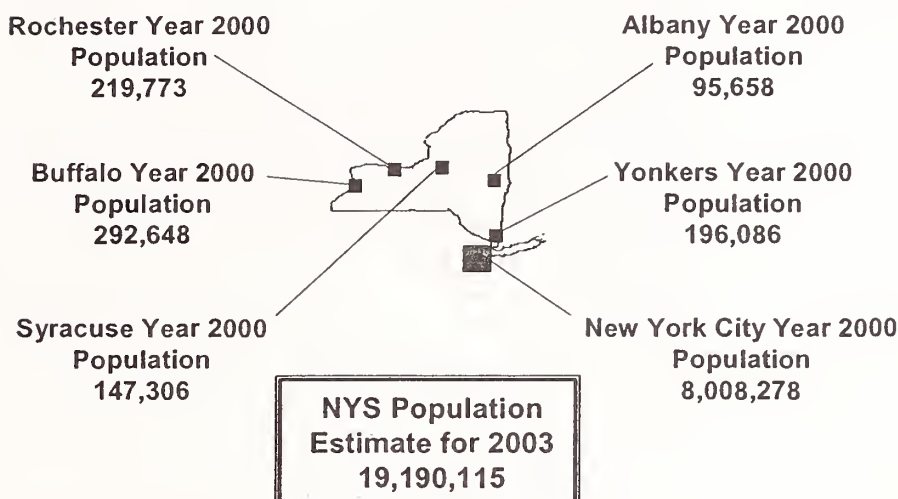
NYS is home to New York City, the largest city in the US and one of the largest in the world. There are five other large urban centers: Buffalo, Rochester, Syracuse and Albany, the state capital, in Upstate NY and Yonkers, just north of NYC in the southern Hudson River Valley region.

Major Urban Centers in NYS

Urban Population Data – Census 2000

Statewide Population Estimate – July 1, 2003

US Census Bureau



New York State and Major Urban Centers by Race/Ethnicity

US Census Bureau – Census 2000 Data

Race/ Ethnicity	NYS	NYC	Albany	Buffalo	Syracuse	Rochester	Yonkers
White	70%	47%	65%	56%	67%	50%	63%
Black	16%	28%	29%	38%	26%	40%	17%
NA/AN	<1%	<1%	<1%	<1%	1%	<1%	<1%
Asian	6%	10%	3%	1%	3%	2%	5%
Native Hawaiian/PI	<1%	<1%	<1%	<1%	<1%	<1%	<1%
Other Race	7%	14%	2%	4%	2%	7%	14%
2+ Races*	3%	5%	3%	3%	4%	4%	5%
Hispanic Any Race*	15%	28%	6%	8%	5%	13%	27%

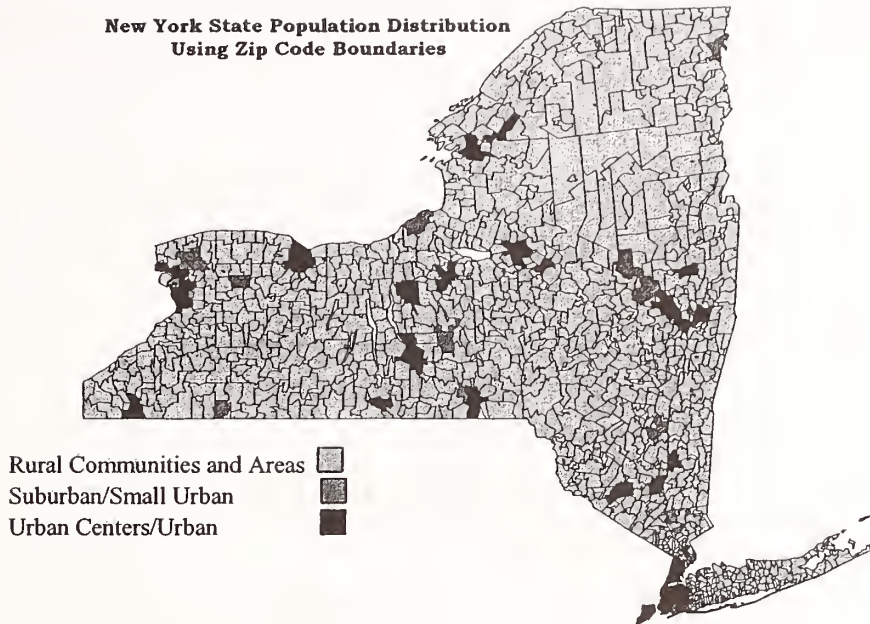
*NB: 2+ Races and Hispanic Ethnicity are expressed as a percent of total NYS population;
single races as a percent of the 'one race' total

Census 2000 Populations for Boroughs and Counties of New York State

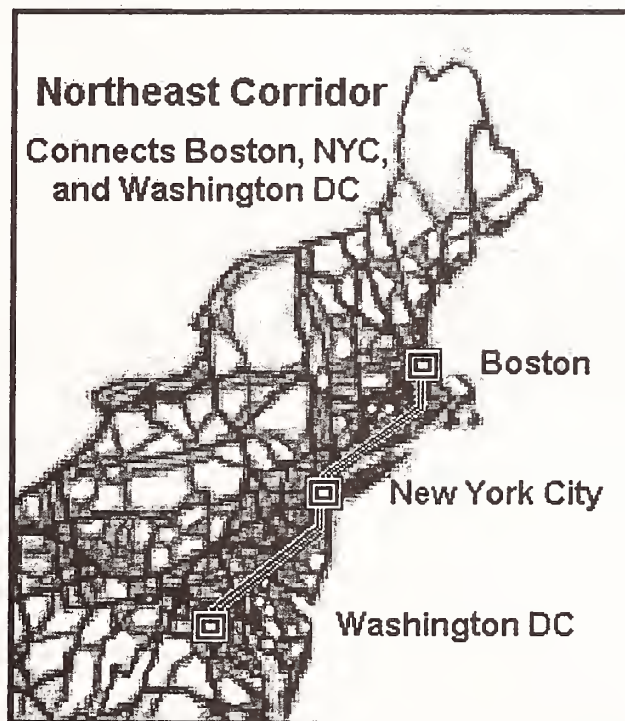
Boroughs of NYC		Counties continued ...		Counties continued ...	
Bronx	1,332,650	Essex	38,851	Putnam	95,745
Brooklyn	2,465,326	Franklin	51,134	Rensselaer	152,538
Manhattan	1,537,195	Fulton	55,073	Rockland	286,753
Queens	2,229,379	Genesee	60,370	St. Lawrence	111,931
Staten Island	443,728	Greene	48,195	Saratoga	200,635
		Hamilton	5,379	Schenectady	146,555
		Herkimer	64,427	Schoharie	31,582
		Jefferson	111,738	Schuyler	19,224
Counties of New York		Lewis	26,944	Seneca	33,342
Albany	294,565	Livingston	64,328	Steuben	98,726
Allegany	49,927	Madison	69,441	Suffolk	1,419,369
Broome	200,536	Monroe	735,343	Sullivan	73,966
Cattaraugus	83,955	Montgomery	49,708	Tioga	51,784
Cayuga	81,963	Nassau	1,334,544	Tompkins	96,501
Chautauqua	139,750	Niagara	219,846	Ulster	177,749
Chemung	91,070	Oneida	235,469	Warren	63,303
Chenango	51,401	Onondaga	458,336	Washington	61,042
Clinton	79,894	Ontario	100,224	Wayne	93,765
Columbia	63,094	Orange	341,367	Westchester	923,459
Cortland	48,599	Orleans	44,171	Wyoming	43,424
Delaware	48,055	Oswego	122,377	Yates	24,621
Dutchess	280,150	Otsego	61,676		
Erie	950,265				

The following map shows NYS divided into 3 settlement types: urban/urban centers of 25,000 population or greater, suburban and small urban communities of 15,000 to 24,000 population, and rural areas and communities of 14,999 or less. The rural nature of the State of New York becomes immediately apparent.

**New York State Population Distribution
Using Zip Code Boundaries**



The "East Coast Corridor" is an extremely large urban swath that runs from Boston to Washington, DC, and includes the New York City SMSA at its approximate mid-point. It is also a major route and/or locale for distribution and sale of controlled substances and for the sex industry.

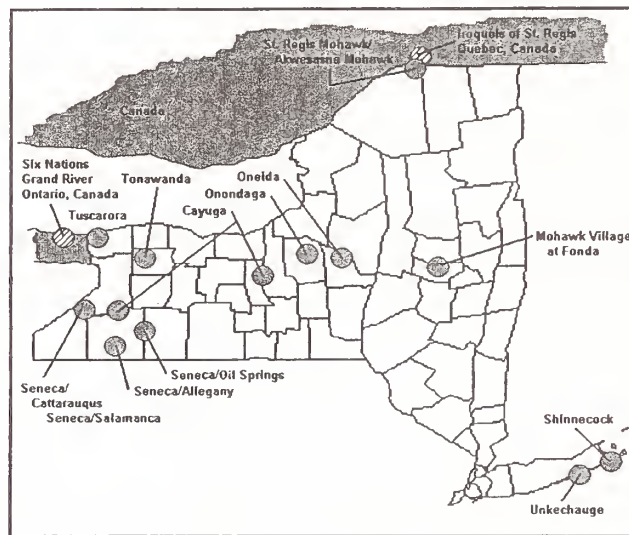


Native American Nations, Territories, Reservations and Villages

New York is also the location of a number of Native American sovereign nations, territories, reservations and villages. These range from the small Mohawk village near Fonda to the larger Onondaga and Oneida Nations.

Native American Sovereign Nations, Territories, Reservations, and Villages

NYS and US/Canadian Border Area

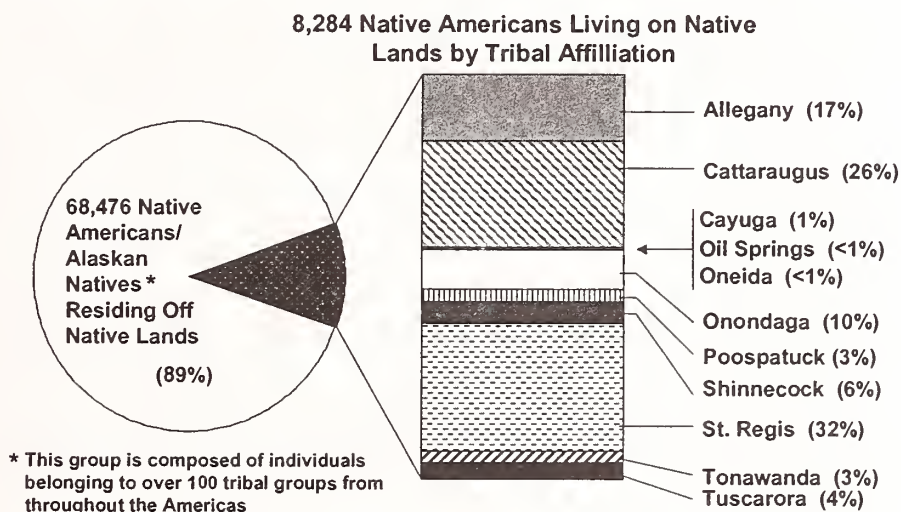


The residents of the Six Nations Grand River Reserve in Ontario, Canada, have the right to freely move across the Canadian/US border as do the people of the Mohawk Nation at the Quebec/US border. This freedom of passage is treaty-based and addresses the latter-day establishment of international borders that cut across existing native settlements and lands. (Both Six Nations and Iroquois of St. Regis are marked on the map above as striped circles.)

While a great number of Native Americans live on or near these lands, approximately 11% of the over seventy-six thousand residing within the boundaries of NYS, many are found in and near the larger urban areas. This group is extremely diverse and includes descendents of tribal groups of Alaska and extending south to Tierra del Fuego.

Native Americans and Alaskan Natives in NYS by Place of Residence

US Census Bureau – American FactFinder 2000



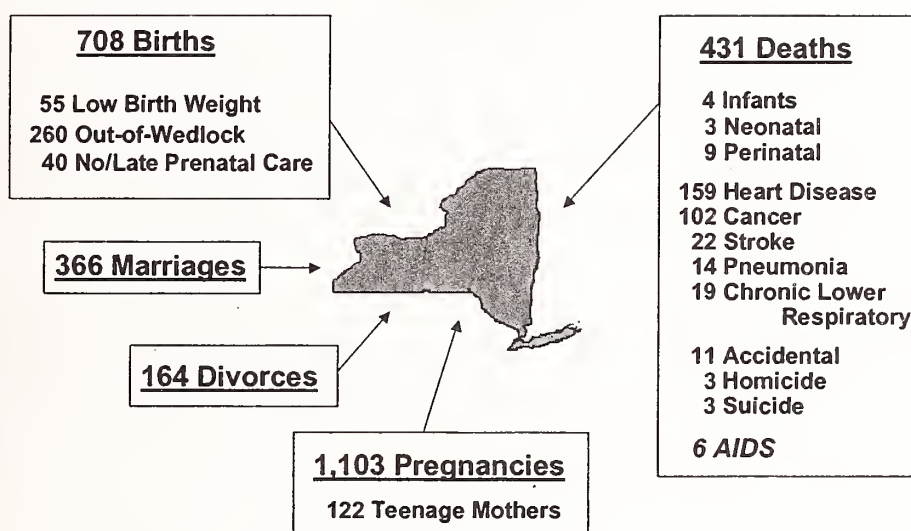
Native American/Alaskan Native Population in New York State by County*
Estimates from the US Census Bureau - 2000

NYS Counties	Estimated Native Americans/Alaskan Natives in County	NYS Counties	Estimated Native Americans/Alaskan Natives in County
<i>Kings</i> (Brooklyn)	10,078	<i>Cayuga</i>	325
<i>New York</i> (Manhattan)	8,289	<i>Madison</i>	323
<i>Queens</i>	8,259	<i>Schenectady</i>	318
<i>Bronx</i>	7,580	<i>Rensselaer</i>	316
<i>Erie</i>	6,228	<i>Wayne</i>	314
<i>Suffolk</i>	3,801	<i>Ontario</i>	294
<i>Onondaga</i>	3,566	<i>Steuben</i>	251
<i>Franklin</i>	2,743	<i>Livingston</i>	248
<i>Monroe</i>	2,441	<i>Clinton</i>	243
<i>Niagara</i>	2,212	<i>Orleans</i>	243
<i>Cattaraugus</i>	2,129	<i>Chemung</i>	233
<i>Westchester</i>	1,835	<i>Greene</i>	195
<i>Orange</i>	1,100	<i>Chenango</i>	169
<i>St. Lawrence</i>	968	<i>Sullivan</i>	168
<i>Richmond</i> (Staten Island)	967	<i>Putnam</i>	163
<i>Rockland</i>	849	<i>Cortland</i>	153
<i>Genesee</i>	808	<i>Warren</i>	139
<i>Albany</i>	643	<i>Otsego</i>	138
<i>Chautauqua</i>	637	<i>Columbia</i>	127
<i>Ulster</i>	561	<i>Washington</i>	127
<i>Oneida</i>	558	<i>Allegany</i>	120
<i>Oswego</i>	523	<i>Herkimer</i>	120
<i>Jefferson</i>	511	<i>Fulton</i>	115
<i>Dutchess</i>	479	<i>Montgomery</i>	112
<i>Broome</i>	378	<i>Essex</i>	109
<i>Tompkins</i>	348	<i>Tioga</i>	101
<i>Saratoga</i>	345		
<ul style="list-style-type: none"> • Only the NYS counties with an estimated Native American/Alaskan Native population over 100 are listed • Counties in italics are part of or include large urban centers 			

Vital Statistics in NYS

Vital statistics in a state as large as NY can be daunting. By breaking down the data into daily components, a clearer picture emerges: "A Day in the Life of New York State" details the vital statistics events in NYS.

A Day in the Life of New York State **Selected Vital Statistic Daily Averages** Bureau of Biometrics, NYSDOH

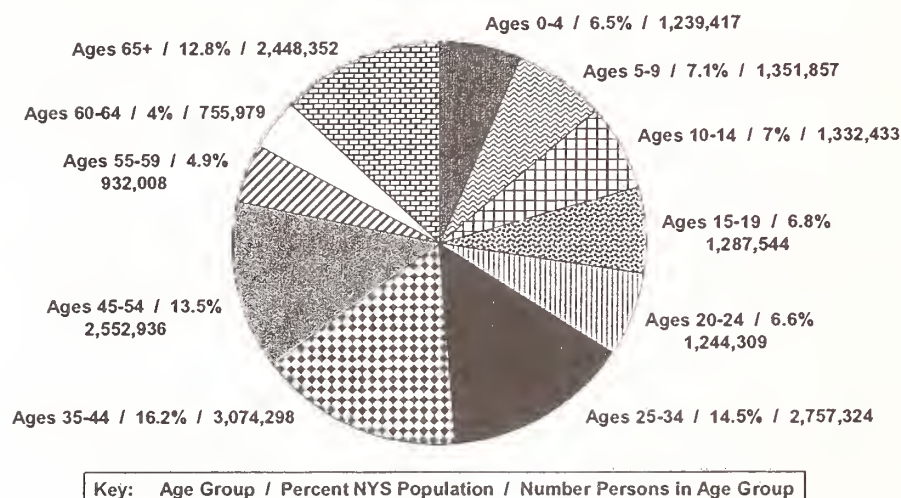


Approximately 50% of the NYS population is ages 20-54, according to Census 2000. The median age is 35.9 years.

New York State Population by Age Group

US Census Bureau – Census 2000

NYS Population is 18,976,457 ♦ Median Age is 35.9 Years



The US Census 2000 notes a total of 9,146,457 males and 9,829,709 females residing in NYS; this yields a male/female ratio of one male for every 1.074 females (m:f=1:1.074).

Among those ages 15 years and older, the three largest 10-year age groups are 25-34, 35-44, and 45-54. Taken together, this new group, ages 25-54 represents more than 44% of the NYS population and roughly duplicates the key risk ages for HIV/AIDS.

Poverty Level and Median Household Income

New York is home to both extremely poor individuals and families and to the wealthy. However, comparing median household income of the 50 states and the District of Columbia, NYS ranks 27th, very near the mid-point between highest and lowest.

Area or State	Rank	Median Income
United States		\$43,527
New Jersey	Highest	\$55,221
West Virginia	Lowest	\$31,210
New York State	27 th of 51*	\$43,160

*Includes District of Columbia

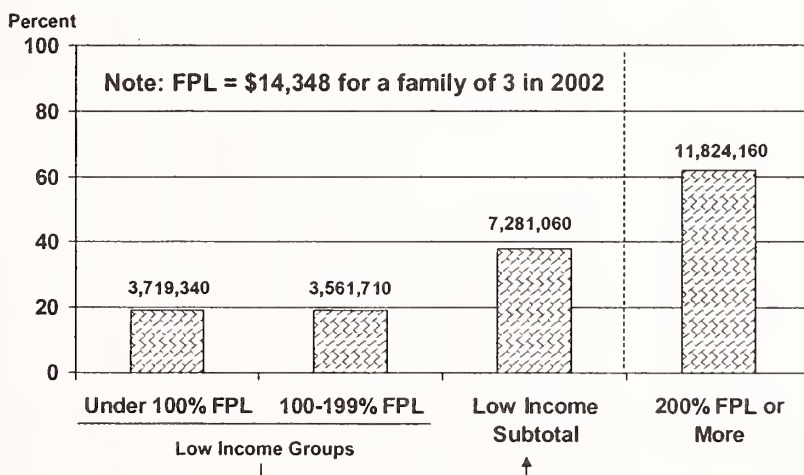
The ability to control one's life and to contribute to the lives of family and friends is often curtailed by a lack of or low level of income. Persons of low income are often forced to make difficult choices between health care, housing, food, and education. In NYS, as in the rest of the US, the poorest persons usually have some access to health care through state or other public insurance plans. The individuals and families just above poverty, who are also defined as "low income" along with those who are poor, may or may not have access to services by income criteria depending on state of residence, citizenship status, age, health, and other defining conditions/situations.

This section describes the population living in poverty in NYS. As living in poverty so clearly affects persons at risk of and living with HIV/AIDS, more detailed discussion of the interaction of poverty and HIV infection is included in the first portion of Question 3.

In the US the Poverty Guidelines are set by the US Department of Health and Human Services and the Poverty Threshold is set by the US Census Bureau. The former is used to determine individual or family eligibility for government and other services; the latter is used statistically to determine the number of people living in poverty. The cut-off point, the Federal Poverty Level (FPL), is the same for both agencies.

NYS Population by Federal Poverty Level 2002-2003

Kaiser Family Foundation State Health reports *Online* (2004)



Poverty Status by Age and Family Status: New York 2003						
2004 Annual Social and Economic Supplement, Current Population Survey, US Census Bureau						
Groups of Interest	Geographic Area	Population*	Population* Below	Percent Below	Population* Below	Percent Below
Among Persons	Geographic definitions	All	100% of	100% of	125%	125% of
Living in Poverty	are found in	Income	Poverty	Poverty	Poverty	Poverty
	Data Notes below	Levels	Threshold	Threshold	Threshold	Threshold
	US	287,699,000	35,861,000	12.5	48,687,000	16.9
Persons of all Ages	NYS	18,922,000	2,707,000	12.7	3,558,000	16.8
Living in Poverty	NY/NJ/CT/PA CMSA	21,538,000	2,728,000	12.7	3,549,000	16.5
	CMSA CC	9,561,000	1,947,000	20.4	2,510,000	26.3
Persons Ages	US	72,999,000	12,866,000	17.6	16,814,000	23.0
0 through 17	NYS	4,524,000	899,000	19.9	1,129,000	25.0
Living in Poverty	NY/NJ/CT/PA CMSA	5,327,000	954,000	17.9	1,196,000	22.5
	CMSA CC	2,324,000	702,000	30.2	853,000	36.7
Persons Ages	US	180,041,000	19,443,000	10.8	26,001	14.4
18 through 64	NYS	11,976,000	1,465,000	12.2	1,908,000	15.9
Living in Poverty	NY/NJ/CT/PA CMSA	13,690,000	1,468,000	10.7	1,918,000	14.0
	CMSA CC	6,094,000	1,038,000	17.0	1,367,000	22.4
Persons Ages	US	34,659,000	3,552,000	10.2	5,872,000	16.9
Ages 65 and Older	NYS	2,422,000	343,000	14.2	521,000	21.5
Living in Poverty	NY/NJ/CT/PA CMSA	2,522,000	306,000	12.1	435,000	17.2
	CMSA CC	1,143,000	207,000	18.1	291,000	25.4
Persons in	US	76,232,000	7,607,000	10.0	10,360,000	13.6
Families with	NYS	4,602,000	573,000	11.9	752,000	15.7
Children and	NY/NJ/CT/PA CMSA	5,466,000	582,000	10.6	760,000	13.9
Living in Poverty	CMSA CC	2,295,000	419,000	18.2	541,000	23.6
Persons in Female-	US	30,827,000	11,324,000	36.7	14,002,000	45.4
headed** Households	NYS	2,464,000	938,000	38.1	1,137,000	46.1
with Children and	NY/NJ/CT/PA CMSA	2,642,000	941,000	35.6	1,143,000	43.3
Living in Poverty	CMSA CC	1,578,000	728,000	46.2	865,000	54.8
Data Notes	* All population data are rounded to the nearest 100,000					
	** No husband present					
Terminology Key	US =	United States				
	NYS =	New York State				
	NY/NJ/CT/PA CMSA =	NY, NJ, Connecticut, Pennsylvania Consolidated Metropolitan Statistical Area				
	CMSA CC =	CMSA Central Counties				

**Boroughs and Counties of NYS by Estimated Number and Percent of
Residents Living in Poverty – 2002**
Small Area Income and Poverty Estimates, US Census Bureau

State, and Counties	All Ages		Less Than 18		Ages 5 – 17 in Families in Poverty		Median Household income
	Number	%	Number	%	Number	%	
New York State	2,611,154	13.9	906,387	20.2	609,201	19.0	42,765
Albany	26,332	9.2	8,293	13.3	5,341	11.7	43,244
Allegany	6,737	14.6	2,095	19.4	1,438	17.9	32,528
Bronx	356,885	26.8	14,493	37.0	101,170	37.1	26,361
Broome	22,919	12.0	7,422	17.5	4,883	15.7	35,903
Cattaraugus	10,528	13.0	3,630	18.6	2,509	17.6	33,632
Cayuga	8,927	11.4	2,944	16.0	2,003	14.8	37,350
Chautauqua	18,718	14.1	6,362	20.7	4,234	18.8	33,518
Chemung	10,841	12.7	3,711	18.3	2,515	17.2	35,859
Chenango	6,588	13.0	2,393	20.0	1,657	18.5	34,293
Clinton	8,704	11.6	2,471	15.2	1,605	13.0	37,763
Columbia	5,938	9.6	1,922	14.2	1,324	12.9	41,207
Cortland	5,859	12.7	1,755	16.8	1,183	15.7	34,867
Delaware	6,004	13.1	1,835	19.1	1,314	18.2	32,265
Dutchess	19,458	7.0	5,658	8.4	3,644	7.3	53,492
Erie	107,552	11.7	37,476	17.6	23,339	14.9	39,502
Essex	4,112	11.3	1,196	15.2	826	13.9	35,046
Franklin	6,836	15.2	2,047	20.1	1,404	18.1	31,820
Fulton	6,452	11.9	2,265	18.7	1,555	17.4	34,180
Genesee	4,946	8.4	1,675	11.8	1,116	10.6	40,579
Green	5,771	12.6	1,712	17.1	1,202	15.8	36,707
Hamilton	454	8.5	101	10.9	70	10.2	34,312
Herkimer	7,309	11.6	2,366	17.0	1,613	15.4	33,323
Jefferson	14,371	13.5	5,288	18.8	3,638	18.5	33,618
Kings	578,707	23.5	218,494	34.3	147,924	33.4	29,961
Lewis	3,346	12.6	1,160	17.7	829	16.9	34,057
Livingston	5,858	10.0	1,674	12.6	1,078	10.9	41,559
Madison	6,374	9.7	1,916	12.3	1,289	11.2	40,018
Monroe	80,923	11.3	29,469	16.7	18,372	14.2	43,435
Montgomery	5,964	12.3	2,209	19.7	1,488	18.4	33,584
Nassau	70,040	5.3	21,297	6.8	13,482	5.9	71,564
New York	275,722	18.0	83,684	30.7	58,161	32.8	43,239
Niagara	22,707	10.5	7,603	15.3	4,890	13.4	37,597
Oneida	27,523	12.4	9,334	18.1	5,982	15.7	35,705
Onondaga	49,555	11.0	16,923	15.2	10,813	13.4	41,198
Ontario	8,014	8.0	2,600	11.0	1,757	10.0	44,534
Orange	34,319	9.7	12,459	12.8	8,074	11.3	52,838
Orleans	5,064	12.4	1,835	17.9	1,260	16.5	36,636
Oswego	14,640	12.2	5,136	17.5	3,431	15.7	37,373
Otsego	6,917	11.9	1,934	15.8	1,323	14.4	33,933
Putnam	3,747	3.8	944	3.9	623	3.4	72,789
Queens	353,999	15.9	110,973	22.6	75,707	22.2	37,876
Rensselaer	13,536	9.0	4,458	12.9	2,916	11.5	43,854
Richmond	42,569	9.3	14,375	13.0	9,435	11.7	52,987
Rockland	26,802	9.2	1,1379	14.6	7,153	13.0	64,804
St. Lawrence	15,290	15.1	4,655	20.0	3,143	18.4	32,377
Saratoga	12,043	5.8	3,458	7.2	2,217	6.3	52,499
Schenectady	14,300	9.9	5,218	15.5	3,367	13.7	43,308

(Table continued)

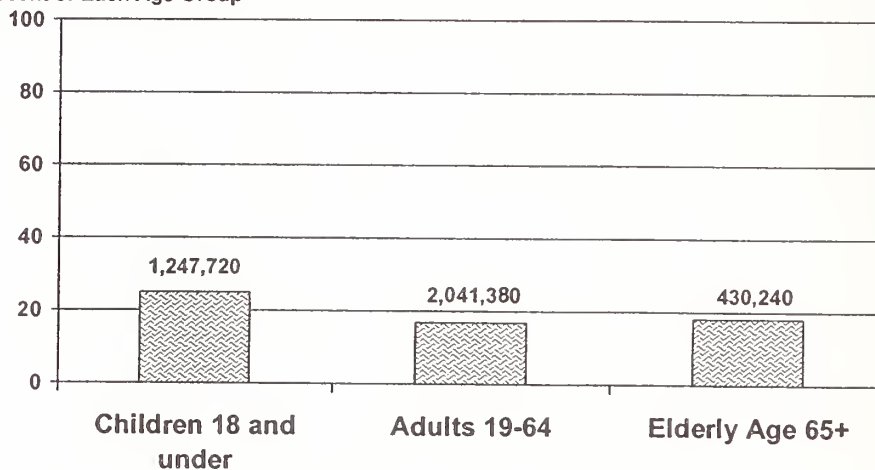
Schoharie	3,711	12.3	1,025	15.5	741	14.8	35,323
Schuyler	2,120	11.2	667	16.2	449	15.6	35,685
Seneca	3,662	11.3	1,172	15.7	816	14.6	36,750
Steuben	12,272	12.5	4,292	18.6	2,898	17.0	35,752
Suffolk	95,274	6.6	30,975	8.6	19,963	7.7	63,118
Sullivan	9,646	13.3	3,296	19.2	2,354	18.7	36,508
Tioga	4,477	8.7	1,550	12.5	1,037	11.2	40,619
Tompkins	11,249	12.6	2,058	12.3	1,361	11.1	37,338
Ulster	18,064	10.4	5,170	13.4	3,444	11.9	40,748
Warren	6,136	9.6	1,996	14.4	1,349	12.9	39,641
Washington	6,574	11.2	2,095	15.5	1,452	14.2	36,739
Wayne	8,408	9.0	3,157	13.5	2,095	12.0	43,551
Westchester	72,548	7.8	23,809	10.5	15,260	9.4	62,817
Wyoming	3,758	9.7	1,137	12.5	784	11.4	38,994
Yates	3,956	12.8	1,181	20.0	851	19.8	34,367

Federal Poverty Level by Age Group

Data for NYS 2002-2003

Kaiser Family Foundation State Health reports *Online* (2004)

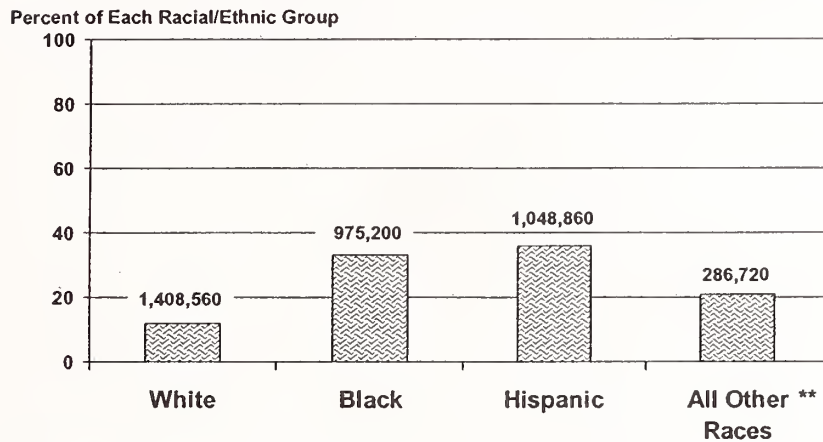
Percent of Each Age Group



Federal Poverty Level by Race/Ethnicity

Data for NYS 2002-2003

Kaiser Family Foundation State Health reports *Online* (2004)



** KFF aggregates all racial/Ethnic data beyond White, Black, and Hispanic. Comparable data for the remaining races and ethnicities is not currently available.

The Foreign-born in NYS

The Kaiser Family Foundation's State Health Facts *Online* reports that for 2003-2003 11% of New York State residents are non-citizens. This group includes foreign students, applicants for citizenship, documented seasonal workers, and other groups of documented and quasi-documented persons, i.e. those whose documentation is in process and/or in adjudication.

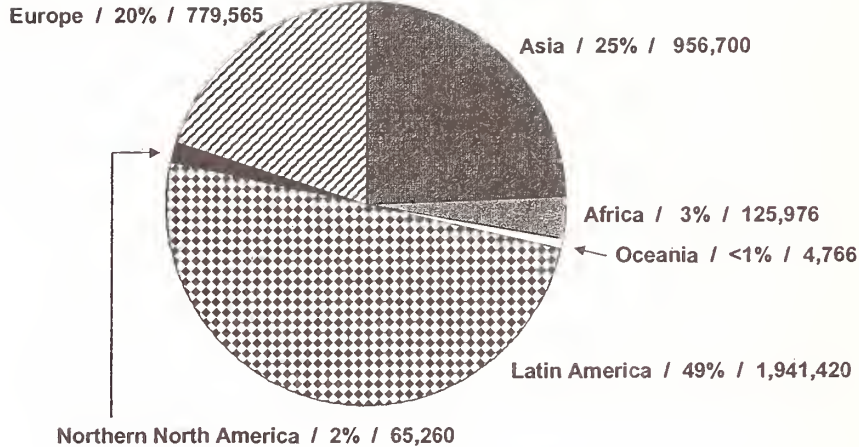
In 2000, NYS ranked third among the top ten US states in estimated number of undocumented residents. The total, 489,000, was reported by the Office of Policy and Planning of the US Immigration and Naturalization Service, now the US Citizenship and Immigration Service, a division of the US Department of Homeland Security.

Many foreign-born individuals seek and complete the process of becoming a US citizen. This process, no more than numbers of years spent living in the US, predicts the ability to speak English sufficiently to access education, employment or care. Even if a resident of an ethnic enclave large enough that daily activities can be carried out in a native language, health emergencies or situations for which confidentiality is preferred may force the individual into an English-only setting.

Foreign Born 5 Years of Age and Older Residing in NYS by Region of Birth

US Census American Community Survey 2003

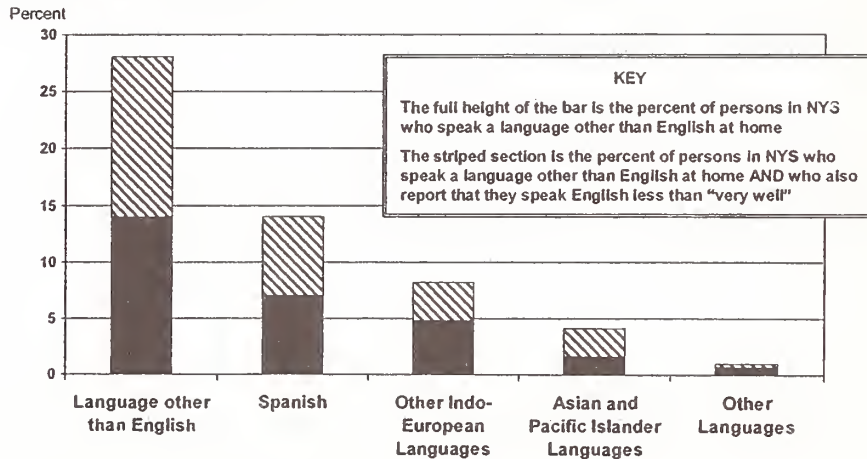
Key: Place of Birth / Percent NYS Population / Number of Persons



Languages Spoken at Home in NYS

US Census American Community Survey 2003

Of the over 17 million people ages 5 and older in NYS, 28% or 4,778,534, speak a language other than English at home. Among these individuals, half or more report that they speak English less than "very well." The remaining 72% of New Yorkers exclusively speak English.



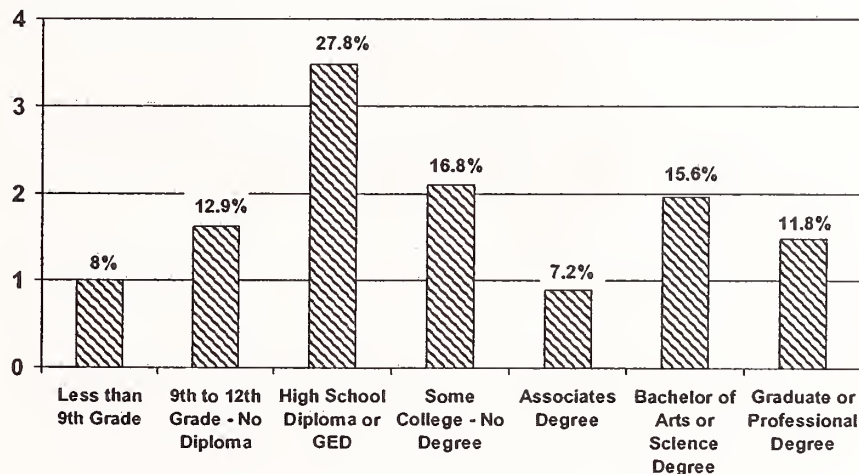
Educational Attainment

NYS, long recognized as a center of learning, exceeds the national average in associate, bachelors, and graduate/professional degrees. Yet even in the presence of such a large proportion of diploma/degree holders, there remains a large group of individuals unable to speak or write sufficient English to secure basic needs for themselves and their families.

Any number of situations can leave an individual without language skills. For example, some individuals may have disabilities that preclude them from learning and/or speaking/reading English and do not use an alternative language such as ASL (American Sign Language). Others may be new to NYS and are learning English as their second, third, or even fifth language. Regardless of cause, lacking communication skills increases the possibility of HIV infection among those at risk of or living with HIV/AIDS by decreasing access to potentially life-saving information.

Educational Attainment in NYS
Percent and Number of Persons 25 Years of Age and Older
Attaining Each Level
US Census Bureau American Community Survey 2003

Numbers of Persons in Millions



Health Insurance Coverage

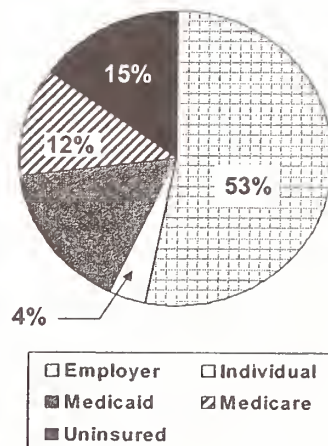
In NYS during 2002-2003, slightly more than 10 million people, or 60% of those persons ages 0-64 years of age, received health insurance through their place of employment or that of a family member. Approximately 3.7 million provided their own insurance or received Medicaid or Medicare. The remainder, slightly less than 3 million people, were uninsured.

Most data describing health insurance coverage report data for persons ages 0 through 64. Persons 65 and older who have or whose spouse has worked for at least 10 years in Medicare-covered employment and who are citizens or permanent residents of the United States are eligible for Medicare. Additionally, some persons with long-term disabilities or certain conditions are also eligible for Medicaid prior to age 65.

The Kaiser Family Foundation's State Health Facts *Online* further reports that the distribution of health insurance among the population of NYS falls within one percentage point of the US distribution in all coverage categories but one: 16% of New Yorkers ages 0-64 are covered by Medicaid as compared to 13% at the national level.

NYS Population Distribution by Insurance Status 2002-2003

Kaiser Family Foundation State
Health Facts *Online* 2003



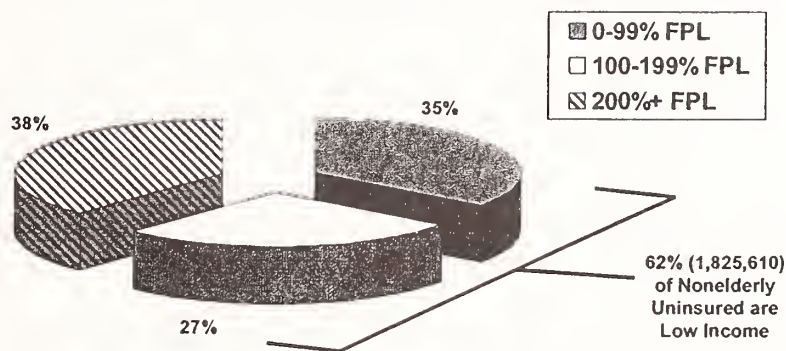
Health coverage is crucial for both care of existing conditions and illnesses and for prevention of future problems. An uninsured person may see a clinician later or not at all when ill and typically will put off important screening exams, such as Pap smears and PSA blood tests for women and men, respectively, or colonoscopy for all persons over 45.

As with other issues of access, among the uninsured in NYS there are differences by race/ethnicity and by Federal Poverty Level.

Distribution of 2,928,840 Nonelderly Uninsured by Federal Poverty Level

New York State Data for 2002-2003

Kaiser Family Foundation State Health *Online* 2004

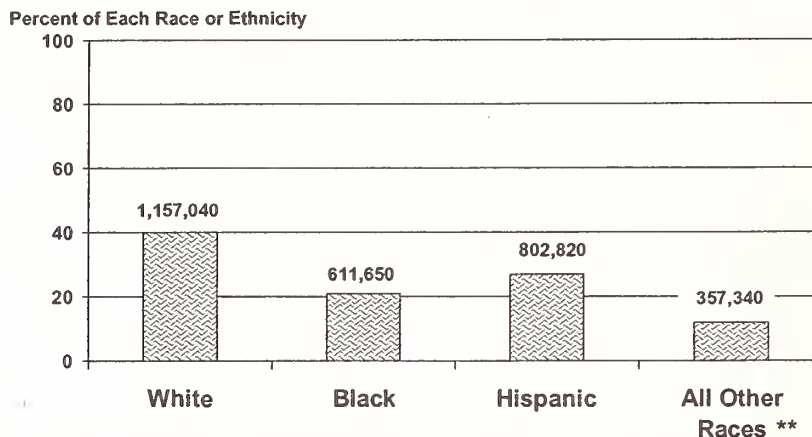


* Nonelderly = those persons ages 0-64; persons 65 and older are covered by Medicare

Distribution of 2,928,840 Nonelderly* Uninsured in NYS by Race/Ethnicity

2002-2003 Data

Kaiser Family Foundation State Health reports *Online* (2004)



* Nonelderly = those persons ages 0-64 (persons 65 and older are covered by Medicare)

** KFF aggregates all racial/Ethnic data beyond White, Black, and Hispanic. Comparable data for the remaining races and ethnicities is not currently available.

New York State has created three programs designed to increase access to health insurance among those low-income persons who are not eligible for Medicaid. First is *Family Health Plus*, a public health insurance program for adults ages 19 to 64 who do not have health insurance but have an income too high to qualify for Medicaid. Family Health Plus is available to single adults, couples without children, and parents with limited income who are residents of New York State, are US citizens, or fall under specific immigration categories. This program, provides comprehensive coverage (prevention, primary care, hospitalization, prescriptions) through local managed care plans. There are no costs or co-pays for *Family Health Plus*.

Child Health Plus is a similar program for children through age 18 and pregnant women. Eligibility is family income defined and insurance is offered at no or very low cost. Those receiving insure for their children at no cost are funded through Medicaid; the remaining children are covered through managed care plans, again without co-pays, as in *Family Health Plus*.

Healthy New York assists small business owners in providing their employees and their employees' families with the health insurance they need and deserve. In addition, uninsured sole proprietors and workers whose employers do not provide health insurance may also purchase comprehensive coverage directly through the *Healthy NY* program. Standardized health insurance benefit packages, made more affordable through state sponsorship, are offered by all health maintenance/managed

care organizations in New York State. Essential health needs such as inpatient and outpatient hospital services, physician services, maternity care, preventative health services, diagnostic and x-ray services, and emergency services are included. Enrollees can chose benefit packages with limited or no prescription drug benefit.

Unfortunately, there remain individuals without health coverage. These individuals, families, and friendship networks are often among those most at risk of HIV infection or who are currently living with HIV/AIDS.

References

For further information on any of these or related topics the following Internet sites may be helpful. If you do not have Internet access personally, visit your local library for access and/or assistance in obtaining the information you need.

Census 2000 -- US Bureau of the Census

<http://www.census.gov/>

HIV/AIDS Surveillance Report -- Center for Disease Control

<http://www.cdc.gov/hiv/stats/hasrlink.htm>

HIV/AIDS Surveillance Semiannual Report -- New York State Department of Health

<http://www.health.state.ny.us/diseases/aids/statistics/index.htm>

State Health Facts *Online* -- Kaiser Family Foundation

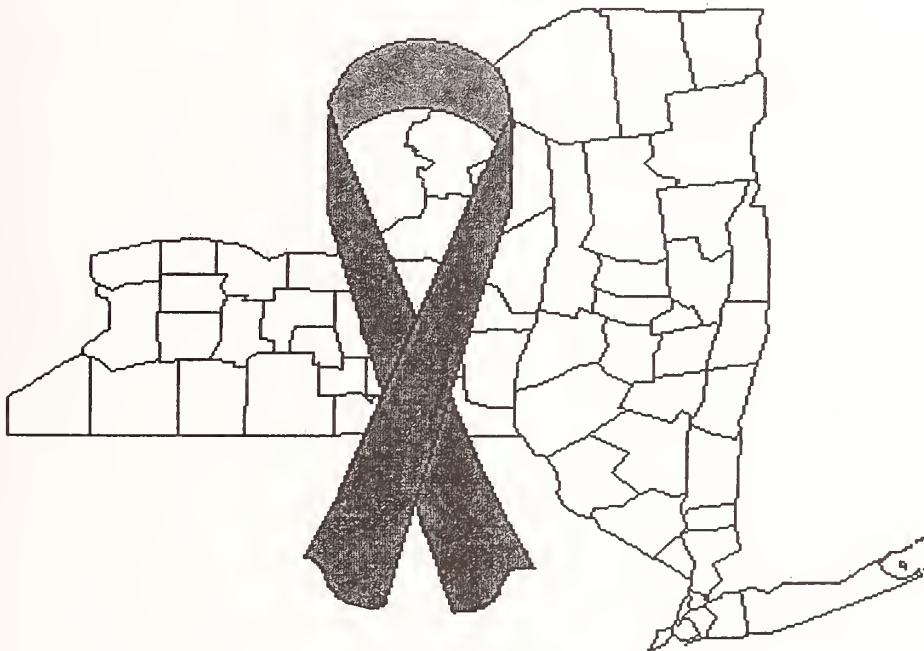
<http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi>

Vital Statistics -- New York State Department of Health

http://www.health.state.ny.us/nysdoh/vital_statistics/index.htm

Question 2:

What is the scope of the HIV/AIDS epidemic in New York State?



Introduction

The material answering “Question 2: What is the scope of the HIV/AIDS epidemic in New York State?” should look familiar to regular readers of the *Epidemiologic Profiles* as it contains the reports, tables, graphs, and charts describing the HIV/AIDS epidemic in NYS.

Included you will also find updates on new and current surveillance initiatives as well as New York State specific data from national surveys such as the Youth Risk Behavior Surveillance Survey, better known as the YRBSS.

There are two new sections:

- [1] The issues of NIR (No identified risk) within the context of the CDC Transmission Category Hierarchy
- [2] A section describing interpretation of graphs, charts, and tables. For those who might want more detail, in the Appendices are presentations prepared for the NYS HIV Prevention Planning Group on tips for reading epidemiologic and scientific articles and on how to read graphs and charts. Also included is a list of acronyms and abbreviations

Further assistance can be found by referring back to the sections following the introduction to this volume, “Data Notes” and “Visual Display of Racial/Ethnic Data.” This material clarifies the importance of inclusiveness in data usage and display.



Data Notes:

- Unless otherwise indicated, HIV and AIDS data from the Bureau of HIV/AIDS Epidemiology are through December 31, 2003 as confirmed through 2004.
- Case numbers for years 2002 and 2003 may increase in the future due to report and processing time.
- As of June 1, 2000, the NYS HIV Reporting and Partner Notification Law requires physicians to report all initial determinations of HIV infection, HIV-related illness, and AIDS. In the period of data collection for this profile, laboratories were required to report all confirmatory HIV antibody tests, all detectable viral loads, and all CD4 lymphocyte counts less than 500 cells/mm³ or 29% total lymphocytes. (As of June 1, 2005, laboratory reporting was expanded to include all values of CD4 lymphocyte counts and all viral loads.)
- Prior to June of 2000, only AIDS cases were required to be reported by law.

Definitions:

- **[Presumed to be] Living with HIV and/or AIDS:** An individual is presumed to be living until a death record is obtained from New York State Vital Statistics or the National Death Index.
- **Prisoners:** Individuals diagnosed with HIV, HIV-related Illness or AIDS while incarcerated in a NYS Department of Corrections facility are listed in the registry at the address of the correctional facility. *Not* included are individuals diagnosed while serving in Federal, county, city, or local jails or other criminal justice facilities.
- **Exposure Categories in the CDC Hierarchy:**
 - **MSM** = men who have sex with men. This includes men who have or have had sex with both men and women.
 - **IDU** = injection drug users.
 - **MSM/IDU** = men who have sex with men and inject drugs.
 - **Heterosexual** = individuals who have had sex with a person or persons of the opposite sex *and* are able to identify the risk of the sexual partner as being injection

drug use, a man who has sex with men, a blood product recipient, or a person with documented HIV or AIDS.

- **Blood-related** = individuals who have received one or more transfusions, blood products, tissue and organ transplants and/or other tissue products.
- **Pediatric** = individuals under age 13. Can be subdivided into '**Perinatal and Other**' (infection during mother's pregnancy, birth and/or breast feeding and all other transmission categories, respectively).
- **Unknown/Under investigation/NIR/NNR/Other*** = unknown/under investigation/no identified risk/no risk reported/Other.
 - These include:
 - case reports currently under investigation by public health representatives. These cases may be reclassified if additional transmission information is identified.
 - persons for whom no mode of exposure was identified due to death or loss to follow-up prior to data collection.
 - persons for whom no transmission risk can be identified in the medical record.
 - persons who have had sex with those of the opposite sex but who are unable to identify the HIV transmission risk or category of those partners. New York City utilizes a subcategory, 'presumed' heterosexual', to further classify individuals in this group.
 - persons not able to meet the criteria for other transmission categories.
 - persons infected through categories not listed above, for example, occupational exposure.

* Please see pages 2-7 through 2-10 for definitions of and issues concerning these terms.

Data Issue: The Growth of “Other/NIR/NRR”

Virtually from the initiation of AIDS case reporting in the very early 1980s, there have been cases reported, surveilled, confirmed, and entered into the registry but either lacked a transmission category or failed to meet the requirements of the CDC transmission hierarchy. These cases were originally reported as NIR (no identified risk), the catch-all category at the bottom of the hierarchy. Later the title of this category was enlarged to Other/NIR/NRR (Other/NIR/no risk reported). These cases also received regular review and repeat surveillance to, first, reclassify if new case information was obtained and, second, to assure that there were no unrecognized routes of transmission.

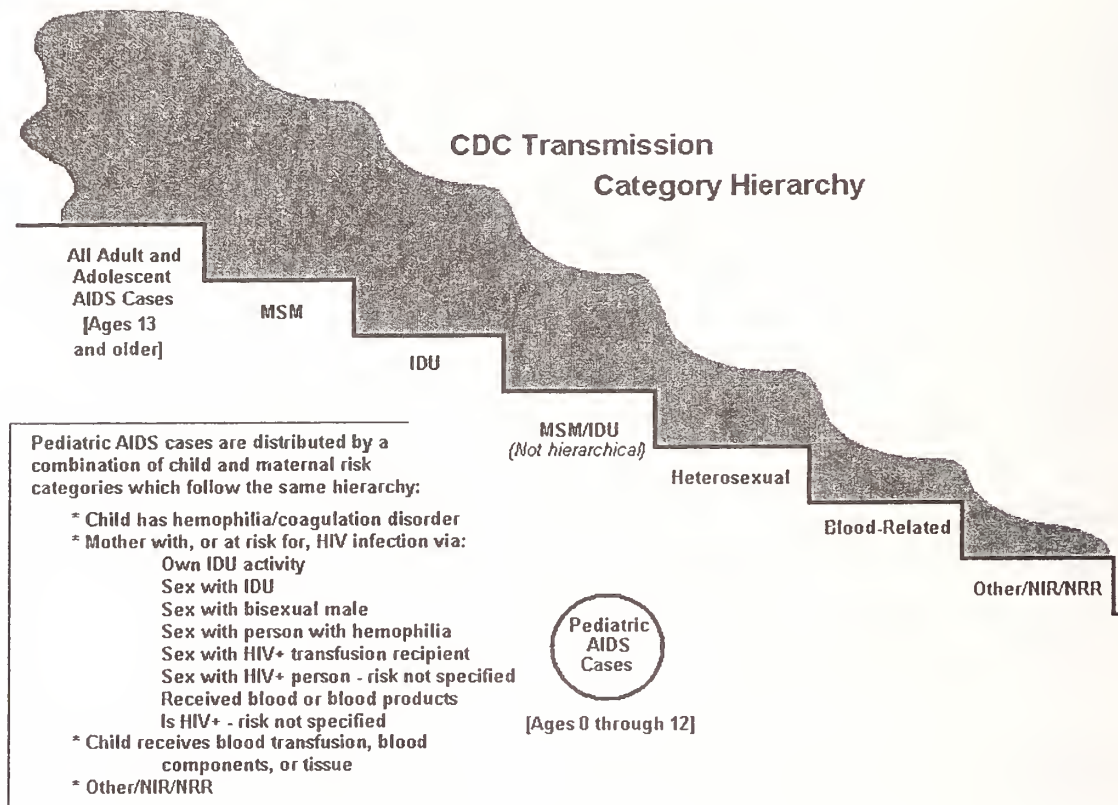
The CDC AIDS Case Definition hierarchy is as follows:

Rank	Category	Common Abbreviations
(Highest Rank)	Men who have Sex with Men	MSM
	Injection Drug User	IDU
	Men who have Sex with Men and who also Inject Drugs	MSM/IDU
	Heterosexual	HET
	Blood transfusions, Blood Products	BLD or BLOOD
(Lowest Rank)	Other, No Identified Risk, No Risk Reported	Other, NIR, NRR

Placement on the hierarchical scale is based on information collected from the medical record and/or the confidential HIV counseling and testing record. On the CDC's HIV/AIDS case report form, this information is found in Section V, Patient History. Numerous states may use state-generated forms; others will use the CDC form. In either case the same data is collected and the various category definitions are shared across the HIV/AIDS Registry System (HARS).

Ideally, all individuals would have a single risk behavior that would neatly place them into the appropriate transmission category according to the hierarchy. In the real world, individuals often have two or more risk behaviors and would fit into more than one transmission category if those categories were not hierarchical. In this case, as each transmission category has an assigned “rank” based on the probability of transmission as recognized earlier in the HIV/AIDS epidemic, the individual case is placed into the first, or highest, category for which the case qualifies, beginning at the highest possible level. If the case fits the criteria of the highest category, that becomes the final classification. Any other risk behaviors are recorded in the registry case record but do not have an effect on the designation of the transmission category. There is one exception to the hierarchy:

men who have sex with men and who also inject drugs have a separate category, MSM/IDU.



The final category, and the topic of this discussion, is that of **Other/NIR/NRR**. This grouping captures individual cases that have failed to meet the criteria for placement either because there is not an appropriate category or because insufficient information is known to make a correct designation. This category also receives cases confirmed as AIDS but for which surveillance is currently ongoing.

The following types of cases will, therefore, be found in the Other/NIR/NRR category:

Occupationally-infected

Typically, these are health care workers and/or first responders who were infected in the course of their professional activities.

NB: From the beginning of the HIV/AIDS epidemic through 2001, the CDC has received reports for 57 individuals who are believed to have become HIV+ from an occupational exposure. Among these 57 people, 86% were reported as infected by exposure to blood. Blood exposure occurred through piercing or cutting the skin in 88% of these reports.

Heterosexually-infected

Persons reporting only heterosexual contact (sexual activity with a person of the opposite sex) but are unable to identify the HIV risk category of their sexual contact(s).

NB: For assignment of a case to the heterosexual category, the individual, male or female, must know and report the HIV transmission category of sexual partner(s).

Information unavailable

Early in the epidemic, there were a relatively small number of individuals who died of HIV/AIDS prior to or without a medical history or surveillance interview -- and -- for whom no knowledgeable proxy was available. Having no information for proper assignment, those cases are designated as NIR or NRR.

Persons from Pattern II Countries

Men and women, primarily women, coming to the US from "Pattern II" countries, i.e. those countries where the male-to-female ratio is 1:1 or greater (example, 1:1.5 or 1:3). Historically, the cases were assigned to the heterosexual transmission category; in the late 1980s, CDC redefined "Heterosexual" to require the transmission category information for the infecting partner(s). As the Pattern II designation was an assumption and there was no corroborating medical and behavioral history, these cases were removed from "Heterosexual" and placed in the final category as Other/NIR/NRR.

Confirmed but Incomplete

Cases that have been confirmed but for which full data has not yet been collected, processed and/or entered into the registry.

Transfusion-related Incomplete

Persons who have reported receipt of a blood transfusion or blood product prior to the screening/heat-treatment of such products and for whom documentation has not yet been completed and/or confirmed.

No Recognized Category

Persons for whom there is not a recognized risk category and/or persons who do not report any behavior which meet the specific risk category criteria.

NB: For example would be a woman with HIV or AIDS who reports sexual contact only with women and denies all other risk behaviors during the time period of interest. As there is not currently a recognized and accepted category for "WSW" (women who have sex with women) this case would be categorized as Other/NIR/NRR.

CDC has noted that HIV reporting has -- and will continue -- to result in a higher proportion of total cases being classified as Other/NIR/NRR. Most initial HIV case reports contain sufficient information for confirmation but are less likely to include risk information for categorization. As new HIV and AIDS cases are surveilled, the missing information is collected, processed, entered, and, in most instances, results in a reclassification and relocation of the case.

New York City Department of Health and Mental Hygiene (NYCDOHMH) epidemiologists, in an effort to reclassify a large and growing NIR category, worked with

NYSDOH epidemiologists to develop criteria for a new sub-category “probable heterosexuals.” This sub-category, currently in use for NYCDOHMH data reports, has been useful in reclassifying a large proportion of NIR cases as “probable heterosexual transmission.” Even with this reclassification effort in place, approximately 60% of cases originally in NIR/NRR, remain there. A recent report from the NYCDOHMH is included as the last item in this section of the *Epidemiologic Profile*.

References:

- [1] Technical notes, *HIV/AIDS Surveillance Report*
www.cdc.gov/hiv/stats/2004SurveillanceReport/htm
- [2] Technical notes, *New York State 2004 HIV/AIDS Surveillance Semiannual Report*
www.health.state.ny.us

New York State HIV/AIDS Surveillance Semiannual Report

**For Cases Diagnosed
through June 2004**

**Bureau of HIV/AIDS Epidemiology
New York State Department of Health**

Issued November 2005

Notice to Readers: Updated November 2005

In 2004 the Center for Disease Control and Prevention (CDC) completed the Interstate Duplication Evaluation Project (IDEP) in which all states were required to participate. The purpose of the project was to identify duplicate cases of HIV/AIDS that have been reported to the National HIV/AIDS Surveillance System by one or more states and assure that the cases are only counted once. If a case was reported by two or more states, the earliest date of diagnosis was used to determine which state the case was assigned to. CDC estimates that 30,000 of the AIDS cases in the national surveillance system were duplicates, representing less than 5% of the almost 1 million cases that have been reported to CDC over the history of the epidemic through 2002. It is anticipated that this process will be conducted on an ongoing basis.

The percent of AIDS cases that were lost in NYS due to this process was approximately 3%. Please note that this loss of AIDS cases will most likely not effect New York's Ryan White funding or other funding based on the AIDS case count because New York's estimated 3% loss in AIDS cases compares favorably with the average loss of cases for the nation which was a little less than 5%. The data presented in the December 2003 and June 2004 Semiannual Reports reflect this change in the AIDS case count for NYS. The December 2002 and 2001 reports have also been updated to reflect this change.

Attention Readers

On June 1, 2000, the New York State Department of Health (NYSDOH) implemented the HIV Reporting and Partner Notification Law. This law enhanced the existing AIDS case reporting by including reporting of HIV and HIV-related illness by health care providers and laboratories to the New York State Commissioner of Health.

The New York State AIDS Surveillance Quarterly Update has been extensively revised to include the HIV infection data in addition to AIDS data. This revised report will be referred to as the New York State HIV/AIDS Surveillance Semiannual Report and will be updated through June and December of each year. The format has been substantially redesigned based on comments from our readers. The data are presented in a more aggregated format to avoid censoring due to small cell sizes, and cases are reported by date of diagnosis rather than date of report. More finely delineated data may still be obtained through our data request unit by calling 518-474-4284. The regional grouping has remained the same: New York City (NYC), New York State (NYS) excluding NYC, Ryan White regions, counties and NYC boroughs. Since a large proportion of cases in NYS excluding NYC areas are prisoners, data on prisoners and the general population continue to be reported separately.

Another major change to the report format is that it only includes cases that have been unduplicated between NYC and the rest of NYS. In all areas of NYS excluding NYC, HIV/AIDS surveillance is conducted by the NYSDOH's Bureau of HIV/AIDS Epidemiology (BHA/E). In NYC, HIV/AIDS surveillance is conducted by the NYC Department of Health's HIV Surveillance and Epidemiology Unit. Often, a case will be reported to both jurisdictions. Since NYC and NYS departments of health report HIV/AIDS data separately to the national Centers for Disease Control and Prevention (CDC) there is often an overlap of cases between the two jurisdictions. CDC unduplicates the data between the two jurisdictions. A case is only counted once and it is assigned to the county of residence at the time of the earliest report. This unduplicated count provides the basis for Ryan White and other federal funding to NYS. The numbers in this report reflect the algorithm used by CDC to unduplicate cases and, therefore, cannot be directly compared to data reported in past issues of the AIDS Surveillance Quarterly Update. Data that has not been unduplicated may also be obtained through our data request unit.

Data presented in this report on risk should be interpreted with caution. Due to the large increase in reported cases, backlogs have developed in case investigations which involve medical chart reviews. Since a medical chart review is usually required to obtain information on the mode of transmission (risk), this backlog has resulted in a large proportion of cases being presented with an unknown risk. The BHA/E will be investigating all cases reported without risk over the next two years, with priority being given to all newly diagnosed HIV and AIDS cases. Due to the large volume of cases in NYC, the HIV Surveillance and Epidemiology Unit will be investigating all AIDS cases reported without risk and a sample of the prevalent HIV cases.

To familiarize yourself with this revised reporting format and definitions contained in this report please read the following section on technical notes.

TECHNICAL NOTES ON HIV/AIDS SURVEILLANCE DATA

Introduction

This is the HIV/AIDS Surveillance Semiannual Report, which is produced by the BHA/E at the NYS Department of Health. Access to this publication is available through the internet at the following address: <http://www.nyhealth.gov/diseases/aids/statistics/index.htm>. Printed copies can be obtained by those without internet access by writing to:

Bureau of HIV/AIDS Epidemiology
P.O. Box 2073 ESP Station Albany, New York 12220-0073

Data presented in this report is generated from information collected and maintained by BHA/E and the NYC Department of Health's HIV Surveillance and Epidemiology Unit.

Reporting Procedures:

As of June 1, 2000, the NYS HIV Reporting and Partner Notification Law (Chapter 163 of the Laws of 1998, PHL 21 Title III) requires health care providers to report all initial determinations of HIV infection, diagnosis of HIV-related illness and diagnosis of AIDS to the NYS Commissioner of Health.* Laboratories are required to report all confirmatory HIV antibody tests, all detectable viral loads and all CD4<500 or 29% of total lymphocytes.

Laboratories conducting HIV-related testing must report directly to the NYS Department of Health either electronically or on paper. For more information call 518-474-4284.

All NYS providers should report using the NYS Confidential Medical Provider HIV/AIDS and Partner/Contact Report Form (PRF). Copies can be obtained by calling 518-474-4284.

NYS providers outside of NYC should mail the completed PRF to:

Division of Epidemiology
P.O. Box 2073 ESP Station Albany, New York 12220-0073

NYC providers should call (212) 442-3388 to arrange pickup of the completed PRF.

*Please note that HIV-infected patients diagnosed with tuberculosis (TB) are also reportable to the local TB control program. Questions regarding TB reporting should be directed to your local or the NYS TB Control Program at (518) 474-4845.

Definition of Terms Used in this Report

Confirmed Case: Reports for which the clinical and demographic data required by the national Centers for Disease Control and Prevention (CDC) to confirm a case have been obtained.

Case Investigation: Reports received without sufficient information to confirm the case or a confirmed case reported without risk are investigated by NYS or NYC public health representatives who examine medical records to obtain demographic information, clinical status and reported HIV exposure (risk).

HIV/AIDS Case Categories: This report classifies cases into the four categories listed below. HIV and AIDS cases are mutually exclusive. The newly diagnosed HIV and AIDS cases are subsets of the living HIV and AIDS categories.

- **Living HIV Cases** - This category includes all reported individuals living with HIV infection who have not developed AIDS. These are considered prevalent HIV cases. This category includes HIV cases reported by a provider indicating an initial HIV diagnosis or an HIV illness and/or by a laboratory reporting a positive western blot or a detectable viral load.
- **Newly Diagnosed HIV Cases** - This is a subset of all living HIV cases that are being reported for the first time by a laboratory reporting a positive western blot or by a physician reporting an initial HIV diagnosis, and has not been reported with AIDS through the end of the reported time period. Please note that HIV reporting just began in June of 2000 and that cases diagnosed prior to this time by a provider other than the current provider reporting the case may be misclassified as a newly diagnosed case. Once the majority of HIV cases in care have been reported, the level of misclassification will decrease.
- **Living AIDS Cases** - This category includes all reported individuals living with AIDS. These are considered prevalent AIDS cases.
- **Newly Diagnosed AIDS Cases** - This is a subset of all living AIDS cases that are being diagnosed and reported with AIDS for the first time. This includes cases that have never been reported before and cases initially reported with HIV infection that have since developed AIDS.
- **Cumulative AIDS Cases** - This category includes all AIDS cases reported since 1983, both living and deceased.

Diagnosis date: The diagnosis date refers to the earliest date on which a clinical or laboratory diagnosis of HIV and AIDS is documented on the provider form, laboratory report or in the patient's medical chart. This date may be months, or even years, prior to the date that the case was reported to the health department. In cases of HIV infection diagnosed prior to June 1, 2000 that have not been investigated, the diagnosis date is the test date of the first laboratory report received.

Report date: The date that the case was confirmed.

Prisoner: Individuals diagnosed and reported while incarcerated in city or county jails or state prisons. Most prisoners are reported from state prisons and are assigned the county of residence of the prison in which they were diagnosed.

Assignment of HIV Exposure Category: Information on possible mode(s) of HIV exposure is typically provided to health care providers during routine medical history taking, and obtained from review of the patient's medical records. An individual may have been potentially exposed to HIV through more than one route. However, for the purpose of surveillance, only one exposure mechanism is considered. (The category of "men who have sex with men and inject drugs" is the only exception to this.) Persons identified with more than one potential exposure route are classified in accordance with the following CDC-defined hierarchy of exposure category:

Adults:

Men who have sex with men (includes bisexual men)

Injection drug users

Men who have sex with men and inject drugs

Hemophiliacs or persons with other clotting disorders

Heterosexual contact with an injection drug user, a bisexual man, a hemophiliac, an HIV-positive blood product recipient, or a person with documented HIV or AIDS Transfusion and/or transplant recipients

Adult with undetermined mode of exposure

Confirmed other risk

Children:

Hemophiliacs or children with other clotting disorder

Mother is an injection drug user

Mother had sex with an injection drug user, a bisexual man, a hemophiliac, an HIV-positive blood Transfusion recipient, an individual with documented HIV or AIDS

Mother received a transfusion or blood products

Mother had AIDS or is HIV-positive

Transfusion or transplant recipient

Child with undetermined mode of exposure

Pediatric other risk

Based on this hierarchy, for example, a woman who may have been exposed to HIV through both injection drug use and through heterosexual contact with an HIV-infected partner would be classified only as an injection drug user, since that mode of exposure precedes heterosexual contact on the hierarchy.

An individual with HIV/AIDS for whom all but heterosexual HIV risk has been ruled out can be classified as heterosexually exposed only if s/he knows the partner's risk and/or HIV status. In the absence of such information, the case is classified as having an undetermined exposure category. In contrast, men who have sex with men and injection drug users need only be behaviorally identified in one of these groups, with no additional documentation required. As a result of the more rigorous standards for identifying heterosexually exposed individuals, it is likely that many heterosexually exposed cases fail to meet these standards. Thus, a proportion of cases with an undetermined exposure category may be heterosexually exposed individuals. Both NYC and NYS surveillance units have been collecting information on "probable heterosexual exposure" which include persons with a history of heterosexual prostitution (sex work or exchange of sex for money or drugs), sexual contact with a prostitute of the opposite sex, multiple sex partners of the opposite sex, sexually transmitted disease, crack/cocaine use or immigration from a country where heterosexual transmission of HIV predominates. This information will be reported in future issues of this report.

Individuals with an undetermined mode of exposure may fall into one of several categories: persons currently under investigation by public health representatives, persons for whom no mode of exposure was identified because the individual died or was lost to follow-up, persons with lack of exposure information in his/her medical chart, and persons for whom adequate follow-up information revealed no identifiable exposure mechanism.

Changes in the AIDS Surveillance Case Definition: A uniform surveillance case definition for AIDS was established by CDC in the early 1980s, and has since been modified three times, each time expanding the range of AIDS-indicator diseases and conditions and incorporating HIV diagnostic tests to improve the sensitivity and specificity of the definition. The first modification occurred in 1985, the second in 1987 and the most recent in 1993. The 1993 expansion of the AIDS case definition for adults and adolescent includes HIV-infected individuals with CD4+ T-lymphocyte counts below 200 cells/mm³ or below 14 percent of total lymphocytes, and individuals diagnosed with pulmonary tuberculosis, recurrent pneumonia or invasive cervical cancer.

Particularly due to the new immunologic criterion of the expanded case definition, the number of cases reported to the NYSDOH and NYCDOH grew immensely following the 1993 modification. The immunologic criterion permitted a substantial number of AIDS diagnoses to be made before the occurrence of the first opportunistic condition. These cases were effectively diagnosed earlier in the spectrum of HIV disease than other AIDS cases diagnosed under the old case definition. The effect of this new criterion was to create a large and sudden increase in the

number of AIDS cases confirmed around 1993, producing the false impression of a dramatic increase in AIDS cases during that period.

Record Updates: When additional surveillance information is received on a confirmed case subsequent to the initial confirmation, data for that case may be updated, resulting in changes in the data reported to the public. Therefore, month to month totals in some data elements (such as mode of exposure and diagnosis date) may change over time. With the implementation of HIV reporting, the number of prevalent HIV and AIDS cases for a specified period of time may change, as individuals initially reported with HIV develop AIDS and are moved from the "HIV" to the "AIDS" category.

Age at diagnosis: The age at diagnosis of HIV and AIDS refers to the individual's age at the earliest, documented diagnosis. The CDC categorizes a case as Pediatric if an AIDS diagnosis was made prior to age 13. Adult and Adolescent cases refer to those cases diagnosed at age 13 or older.

Mortality Information: Vital status of cases is determined from updated case reports, death certificate files maintained by the NYSDOH and NYCDOH Vital Records, and the National Death Index. Unless a case is known to be deceased from these sources, they are presumed to be alive.

Prisoners: Cases categorized as "Prisoners" have been diagnosed while incarcerated in city or county jails or one of the NYS Department of Corrections (DOCS) facilities throughout NYS. Most prisoners are reported from a NYSDOCS facility. Prison cases are often presented separately from general population data because, if diagnosed while incarcerated, residence reflects the address of the correctional facility, rather than their home address.

Regional Groupings: For this report, cases are assigned to the county of residence at time of earliest diagnosis. In NYC, data include all individuals who were residents of one of the five New York City boroughs at the time of initial diagnosis. NYS excluding NYC include all individuals whose residence was anywhere in NYS outside of NYC at the time of initial diagnosis.

TABLE OF CONTENTS:

STATEWIDE

Table 1	AIDS cases by Region and Year of Diagnosis.....	Page 11
Table 2A	Living and Cumulative HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk.....	Page 12
Table 2B	Newly Diagnosed HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk.....	Page 13

REGIONAL

Table 3A	NYC - Living and Cumulative HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk.....	Page 14
Table 3B	NYC - Newly Diagnosed HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk.....	Page 15
Table 4A	NYC excluding NYC - Living and Cumulative HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk.....	Page 16
Table 4B	NYC excluding NYC - Newly Diagnosed HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk.....	Page 17

NYC Excluding NYC – COUNTY

Table 5A	Living and Cumulative HIV/AIDS by County.....	Pages 18-19
Table 5B	Newly Diagnosed HIV/AIDS cases by County.....	Pages 20-21

NYC BY GENDER

Table 6A	Males - Living HIV/AIDS cases by Age, Race/Ethnicity and Risk.....	Page 22
Table 6B	Males - Newly Diagnosed HIV/AIDS cases by Age, Race/Ethnicity and Risk.....	Page 23
Table 6C	Females - Living HIV/AIDS cases by Age, Race/Ethnicity and Risk.....	Page 24
Table 6D	Females - Newly Diagnosed HIV/AIDS cases by Age, Race/Ethnicity and Risk.....	Page 25

NYC Excluding NYC by GENDER (excludes Prisoners)

Table 7A	Males - Living HIV/AIDS cases by Age, Race/Ethnicity and Risk.....	Page 26
Table 7B	Males - Newly Diagnosed HIV/AIDS cases by Age, Race/Ethnicity and Risk.....	Page 27
Table 7C	Females - Living HIV/AIDS cases by Age, Race/Ethnicity and Risk.....	Page 28
Table 7D	Females - Newly Diagnosed HIV/AIDS cases by Age, Race/Ethnicity and Risk.....	Page 29

PRISONERS - (NYS Excluding NYC)

Table 8A	Living HIV/AIDS cases by Gender, Age and Race/Ethnicity.....	Page 30
Table 8B	Newly Diagnosed HIV/AIDS cases by Gender, Age and Race/Ethnicity.....	Page 31

NYC Excluding NYC

Table 9A	Living and Cumulative HIV/AIDS cases by Ryan White Region.....	Page 32
Table 9B	Newly Diagnosed HIV/AIDS cases by Ryan White Region.....	Page 33

NYC Excluding NYC - Ryan White Regions

The following two tables have been generated for each of the Ryan White Regions:

A - Living and Cumulative HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk	
B - Newly Diagnosed HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk	
Table 10 - A,B	Albany Ryan White Region Pages 34-35
Table 11 - A,B	Binghamton Ryan White Region Pages 36-37
Table 12 - A,B	Buffalo Ryan White Region Pages 38-39
Table 13 - A,B	Lower Hudson Ryan White Region Pages 40-41
Table 14 - A,B	Mid Hudson Ryan White Region Pages 42-43
Table 15 - A,B	Nassau/Suffolk Ryan White Region Pages 44-45
Table 16 - A,B	Rochester Ryan White Region Pages 46-47
Table 17 - A,B	Syracuse Ryan White Region Pages 48-49

NYC – Boroughs

Table 18A	HIV/AIDS Cases Diagnosed through June 2004.....	Page 50
Table 18B	Newly Diagnosed HIV/AIDS Cases, Diagnosed July 2003-June 2004.....	Page 51

The following two tables have been generated for each of the Boroughs:

A - Living and Cumulative HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk	
B - Newly Diagnosed HIV/AIDS cases by Gender, Age, Race/Ethnicity and Risk	
Table 19 - A,B	Bronx..... Pages 52-53
Table 20 - A,B	Brooklyn..... Pages 54-55
Table 21 - A,B	Manhattan..... Pages 56-57
Table 22 - A,B	Queens..... Pages 58-59
Table 23 - A,B	Staten Island..... Pages 60-61

Table 1
New York State AIDS Cases* by Region and Year of Diagnosis

Year	Number of Cases Diagnosed		
	NYC	Upstate	Total
Prior to 1981	49	0	49
1981	149	7	156
1982	491	33	524
1983	1,046	125	1,171
1984	1,763	249	2,012
1985	2,715	450	3,165
1986	3,896	706	4,602
1987	4,876	1,025	5,901
1988	6,029	1,288	7,317
1989	6,346	1,562	7,908
1990	7,199	1,725	8,924
1991	8,321	2,124	10,445
1992	9,998	2,606	12,604
1993	11,501	2,829	14,330
1994	11,354	2,617	13,971
1995	10,123	2,663	12,786
1996	8,349	2,193	10,542
1997	6,715	1,564	8,279
1998	5,105	1,258	6,363
1999	4,797	1,209	6,006
2000	5,726	1,389	7,115
2001	4,911	1,294	6,205
2002	4,077	1,173	5,250
2003	4,706	1,100	5,806
Through June 2004**	2,129	520	2,649
TOTAL	132,371	31,709	164,080

*Cases reported and confirmed through June 2005

**Data incomplete due to lag in reporting

Table 2A
HIV/AIDS Cases by Gender, Age, Race/Ethnicity and Risk Diagnosed through June 2004

	Living HIV*		Living		AIDS**	
	Number	Percent	Number	Percent	Number	Percent
Gender						
Male	23,593	64.5	47,270	70.8	122,546	74.7
Female	12,772	34.9	19,542	29.2	41,534	25.3
Unk	221	0.6	0	0.0	0	0.0
TOTAL	36,586	100.0	66,812	100.0	164,080	100.0
Age Group						
12 & under	1,763	4.8	835	1.2	2,322	1.4
13-19	882	2.4	596	0.9	842	0.5
20-24	2,664	7.3	1,968	2.9	4,011	2.4
25-29	4,367	11.9	6,364	9.5	15,771	9.6
30-49	22,731	62.1	48,446	72.5	118,622	72.3
50+	4,039	11.0	8,603	12.9	22,512	13.7
Unk	140	0.4	0	0.0	0	0.0
TOTAL	36,586	100.0	66,812	100.0	164,080	100.0
Race/Ethnicity						
White	8,603	23.5	14,848	22.2	42,455	25.9
Black	16,101	44.0	30,369	45.5	71,953	43.9
Hispanic	10,466	28.6	20,512	30.7	47,951	29.2
Asian/Pi	372	1.0	616	0.9	1,144	0.7
Native Am	58	0.2	69	0.1	111	0.1
Multi Race	69	0.2	91	0.1	95	0.1
Other/Unk	917	2.5	307	0.5	371	0.2
TOTAL	36,586	100.0	66,812	100.0	164,080	100.0
Risk						
MSM	9,462	25.9	16,702	25.0	46,323	28.2
IDU	5,179	14.2	19,337	28.9	63,569	38.7
MSM/IDU	467	1.3	1,486	2.2	4,857	3.0
Heterosexual	5,865	16.0	10,065	15.1	18,044	11.0
Blood Prod.	147	0.4	434	0.6	1,372	0.8
Pediatric Risk	1,438	3.9	932	1.4	2,415	1.5
Other/Unk	14,028	38.3	17,856	26.7	27,500	16.8
TOTAL	36,586	100.0	66,812	100.0	164,080	100.0

*All cases reported and confirmed from June 2000 - June 2005

**All cases reported and confirmed from 1983 - June 2005

STATEWIDE: Includes all 62 Counties

Table 2B
Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

Gender	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Male	2,045	66.4	3,590	67.4
Female	1,036	33.6	1,738	32.6
TOTAL	3,081	100.0	5,328	100.0
Age Group				
12 & under	19	0.6	8	0.2
13-19	140	4.5	53	1.0
20-24	340	11.0	173	3.2
25-29	370	12.0	358	6.7
30-49	1,795	58.3	3,610	67.8
50+	416	13.5	1,126	21.1
Unk	1	0.0	0	0.0
TOTAL	3,081	100.0	5,328	100.0
Race/Ethnicity				
White	587	19.1	970	18.2
Black	1,560	50.6	2,687	50.4
Hispanic	830	26.9	1,549	29.1
Asian/Pi	44	1.4	74	1.4
Native Am	9	0.3	10	0.2
Multi Race	30	1.0	13	0.2
Other/Unk	21	0.7	25	0.5
TOTAL	3,081	100.0	5,328	100.0
Risk				
MSM	982	31.9	1,279	24.0
IDU	279	9.1	875	16.4
MSM/IDU	29	0.9	89	1.7
Heterosexual	516	16.7	893	16.8
Blood Prod.	18	0.6	41	0.8
Pediatric Risk	15	0.5	17	0.3
Other/Unk	1,242	40.3	2,134	40.1
TOTAL	3,081	100.0	5,328	100.0

*Cases reported and confirmed through June 2005

NEW YORK CITY - TOTAL

Table 3A
HIV/AIDS Cases by Gender, Age, Race/Ethnicity and Risk Diagnosed through June 2004

Gender	Living HIV		Living AIDS*		Cumulative	
	Number	Percent	Number	Percent	Number	Percent
Male	17,721	63.9	36,685	70.0	97,866	73.9
Female	9,811	35.4	15,708	30.0	34,505	26.1
Unk	220	0.8	0	0.0	0	0.0
TOTAL	27,752	100.0	52,393	100.0	132,371	100.0
Age Group						
12 & under	1,510	5.4	724	1.4	2,010	1.5
13-19	643	2.3	464	0.9	641	0.5
20-24	2,012	7.2	1,562	3.0	3,178	2.4
25-29	3,266	11.8	4,906	9.4	12,331	9.3
30-49	17,133	61.7	37,631	71.8	95,238	71.9
50+	3,168	11.4	7,106	13.6	18,973	14.3
Unk	20	0.1	0	0.0	0	0.0
TOTAL	27,752	100.0	52,393	100.0	132,371	100.0
Race/Ethnicity						
White	5,913	21.3	10,222	19.5	30,202	22.8
Black	12,307	44.3	23,992	45.8	59,010	44.6
Hispanic	8,272	29.8	17,284	33.0	41,714	31.5
Asian/Pi	339	1.2	572	1.1	1,064	0.8
Native Am	29	0.1	31	0.1	56	0.0
Multi Race	11	0.0	10	0.0	10	0.0
Other/Unk	881	3.2	282	0.5	315	0.2
TOTAL	27,752	100.0	52,393	100.0	132,371	100.0
Risk						
MSM	7,692	27.7	13,542	25.8	38,212	28.9
IDU	3,012	10.9	14,667	28.0	50,760	38.3
MSM/IDU	300	1.1	1,010	1.9	3,565	2.7
Heterosexual	4,165	15.0	7,724	14.7	14,273	10.8
Blood Prod.	106	0.4	300	0.6	885	0.7
Pediatric Risk	1,263	4.6	805	1.5	2,075	1.6
Other/Unk	11,214	40.4	14,345	27.4	22,601	17.1
TOTAL	27,752	100.0	52,393	100.0	132,371	100.0

*All cases reported and confirmed from June 2000 - June 2005
**All cases reported and confirmed from 1983 - June 2005

Table 3B
Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

Gender	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Male	1,675	67.2	2,837	66.6
Female	817	32.8	1,422	33.4
TOTAL	2,492	100.0	4,259	100.0
Age Group	12 & under	14	7	0.2
	13-19	108	4.3	1.0
	20-24	274	11.0	3.5
	25-29	303	12.2	6.4
	30-49	1,469	58.9	67.6
	50+	324	13.0	21.4
	TOTAL	2,492	100.0	100.0
Race/Ethnicity	White	413	16.6	14.9
	Black	1,269	50.9	51.4
	Hispanic	739	29.7	31.4
	Asian/PI	42	1.7	1.6
	Native Am	6	0.2	0.1
	Multi Race	3	0.1	0.0
	Other/Unk	20	0.8	0.6
	TOTAL	2,492	100.0	100.0
Risk	MSM	829	33.3	24.1
	IDU	212	8.5	15.0
	MSM/IDU	21	0.8	1.6
	Heterosexual	390	15.7	15.9
	Blood Prod.	12	0.5	0.7
	Pediatric Risk	10	0.4	0.3
	Other/Unk	1,018	40.9	42.4
	TOTAL	2,492	100.0	100.0

*Cases reported and confirmed through June 2005

Table 4A
HIV/AIDS Cases by Gender, Age, Race/Ethnicity and Risk Diagnosed through June 2004

Gender	Living HIV*		AIDS**	
	Number	Percent	Number	Percent
Male	5,872	66.5	10,585	73.4
Female	2,961	33.5	3,834	26.6
Unk	1	0.0	0	0.0
TOTAL	8,834	100.0	14,419	100.0
Age Group	12 & under	253	2.9	1.1
	13-19	239	2.7	0.9
	20-24	652	7.4	2.8
	25-29	1,101	12.5	10.1
	30-49	5,598	63.4	75.0
	50+	871	9.9	10.4
	Unk	120	1.4	0.0
	TOTAL	8,834	100.0	31,709
Race/Ethnicity	White	2,690	30.5	32.1
	Black	3,794	42.9	44.2
	Hispanic	2,194	24.8	22.4
	Asian/PI	33	0.4	0.3
	Native Am	29	0.3	0.3
	Multi Race	58	0.7	0.6
	Other/Unk	36	0.4	0.2
	TOTAL	8,834	100.0	31,709
Risk	MSM	1,770	20.0	21.9
	IDU	2,167	24.5	32.4
	MSM/IDU	167	1.9	3.3
	Heterosexual	1,700	19.2	16.2
	Blood Prod.	41	0.5	0.9
	Pediatric Risk	175	2.0	0.9
	Other/Unk	2,814	31.9	24.3
	TOTAL	8,834	100.0	31,709

*All cases reported and confirmed from June 2000 - June 2005

**All cases reported and confirmed from 1983 - June 2005

Table 4B
Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Total HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	370	62.8	753	70.4
Female	219	37.2	316	29.6
TOTAL	589	100.0	1,069	100.0
Age Group				
12 & under	5	0.8	1	0.1
13-19	32	5.4	10	0.9
20-24	66	11.2	26	2.4
25-29	67	11.4	85	8.0
30-49	326	55.3	731	68.4
50+	92	15.6	216	20.2
Unk	1	0.2	0	0.0
TOTAL	589	100.0	1,069	100.0
Race/Ethnicity				
White	174	29.5	337	31.5
Black	291	49.4	498	46.6
Hispanic	91	15.4	210	19.6
Asian/Pi	2	0.3	5	0.5
Native Am	3	0.5	7	0.7
Multi Race	27	4.6	12	1.1
Other/Unk	1	0.2	0	0.0
TOTAL	589	100.0	1,069	100.0
Risk				
MSM	153	26.0	253	23.7
IDU	67	11.4	236	22.1
MSM/IDU	8	1.4	20	1.9
Heterosexual	126	21.4	216	20.2
Blood Prod.	6	1.0	13	1.2
Pediatric Risk	5	0.8	4	0.4
Other/Unk	224	38.0	327	30.6
TOTAL	589	100.0	1,069	100.0

*Cases reported and confirmed through June 2005

Table 5A
HIV/AIDS Cases Diagnosed through June 2004

County	Living HIV**		Living AIDS**		Cumulative
	Includes Prisoners	Excludes Prisoners	Includes Prisoners	Excludes Prisoners	
Albany	333	366	489	510	1,064
Allegany	4	4	9	10	22
Broome	109	111	130	134	270
Cattaraugus	17	52	20	47	76
Cayuga	20	102	44	143	295
Chautauqua	57	103	61	79	113
Chemung	34	87	32	93	249
Chenango	14	20	24	32	54
Clinton	20	108	28	226	462
Columbia	32	76	30	57	132
Cortland	6	6	8	8	21
Delaware	19	19	20	21	40
Dutchess	196	401	368	667	1,535
Erle	548	633	801	901	1,835
Essex	11	54	17	82	181
Franklin	14	233	20	228	36
Fulton	17	19	19	20	39
Genesee	16	16	21	23	43
Greene	21	61	38	119	69
Hamilton	1	1	1	1	2
Herkimer	13	13	13	13	31
Jefferson	26	188	37	171	73
Lewis	21	21	5	6	11
Livingston	15	97	31	104	67
Madison	12	13	15	27	34
Monroe	626	656	993	1,012	2,118
Montgomery	26	28	29	29	71
Nassau	682	704	1,502	1,527	3,764
Niagara	47	50	80	84	221
Oncida	104	335	159	485	929
Onondaga	268	275	470	481	1,057
Ontario	23	24	36	37	58
Orange	213	298	471	599	1,331

*All cases reported and confirmed from June 2000 - June 2005

**All cases reported and confirmed from 1983 - June 2005

Table 5A

HIV/AIDS Cases Diagnosed through June 2004

County	Living HIV			AIDS		
	Includes Prisoners	Excludes Prisoners	Living	Includes Prisoners	Excludes Prisoners	Cumulative
Albany	14	240	25	238	42	359
Allegany	23	23	40	40	82	82
Broome	21	21	30	31	65	66
Cattaraugus	26	27	73	74	167	168
Chemung	82	87	126	130	254	258
Chautauque	150	153	399	466	864	933
Columbia	39	84	77	133	177	294
Cortland	141	149	167	179	375	388
Delaware	14	20	8	12	33	37
Dutchess	2	7	2	4	12	14
Essex	14	102	8	59	20	76
Franklin	32	174	45	204	75	315
Fulton	17	18	25	25	71	71
Greene	723	743	1,500	1,526	3,722	3,781
Hamilton	115	173	183	255	475	625
Herkimer	9	9	11	11	28	28
Jefferson	18	19	63	66	120	123
Lewis	125	246	259	436	593	905
Livingston	19	19	28	28	58	58
Madison	10	100	19	107	45	284
Monroe	36	51	33	46	79	97
Montgomery	797	1,064	1,937	2,214	4,500	4,987
Nassau	6	124	11	157	19	315
Niagara	7	7	2	2	9	9
Onondaga	0	0	0	0	1	1
Orleans	6,005	8,834	11,092	14,419	25,677	31,709
Oswego						
Otsego						

* All cases reported and confirmed from June 2000 - June 2005

** All cases reported and confirmed from 1983 - June 2005

Table 5B

Newly Diagnosed HIV/AIDS Cases* Diagnosed July 2003 - June 2004

County	Living HIV		AIDS	
	Includes Prisoners	Excludes Prisoners	Includes Prisoners	Excludes Prisoners
Albany	33	33	46	49
Allegany	1	1	1	1
Broome	5	5	13	13
Cattaraugus	1	1	3	4
Chemung	1	1	5	9
Chautauque	4	4	6	7
Chemung	2	2	2	11
Chenango	0	0	2	2
Clinton	0	1	2	9
Columbia	2	2	1	1
Cortland	0	0	2	2
Delaware	1	1	1	1
Dutchess	15	18	29	46
Essex	47	49	73	75
Franklin	0	2	0	2
Fulton	1	4	4	11
Greene	3	3	2	2
Hamilton	0	1	5	10
Herkimer	0	0	0	0
Jefferson	2	2	1	1
Lewis	1	1	4	7
Livingston	1	1	0	0
Madison	0	1	3	4
Monroe	0	0	1	1
Montgomery	63	63	75	77
Nassau	3	3	1	1
Niagara	65	65	109	113
Onondaga	5	5	9	11
Orleans	7	7	17	31
Oswego	19	19	33	34
Otsego	1	1	4	4
Orange	19	19	59	80
Orleans	1	1	3	10
Oswego	2	2	4	4
Otsego	1	1	4	4

* Cases reported and confirmed through June 2005

NEW YORK STATE: (Excluding NYC) by County

Table 5B

Newly Diagnosed HIV/AIDS Cases* Diagnosed July 2003 - June 2004

County	Initial HIV Diagnosis		Initial AIDS Diagnosis	
	Excludes Prisoners	Includes Prisoners	Excludes Prisoners	Includes Prisoners
Putnam	2	2	7	7
Rensselaer	15	15	16	16
Rockland	19	19	23	23
Saratoga	1	3	12	14
Schenectady	19	19	16	18
Schoharie	1	1	2	2
Seneca	3	5	1	7
St Lawrence	1	2	7	11
Steuben	0	0	1	1
Suffolk	77	77	113	114
Sullivan	12	14	10	12
Tioga	1	1	3	3
Tompkins	2	2	2	2
Ulster	16	17	18	25
Warren	2	2	1	1
Washington	0	0	2	3
Wayne	4	4	1	1
Westchester	81	86	139	162
Wyoming	1	1	1	10
Unk	0	0	0	0
TOTAL	563	589	899	1,069

*Cases reported and confirmed through June 2005

NEW YORK CITY - Males

Table 6A

Living HIV/AIDS Cases (including prisoners) by Age, Race/Ethnicity and Risk Diagnosed through June 2004*

Age Group	Living HIV		Living AIDS	
	Number	Percent	Number	Percent
12 & under	731	4.1	355	1.0
13-19	330	1.9	232	0.6
20-24	1,191	6.7	911	2.5
25-29	2,076	11.7	3,209	8.7
30-49	11,243	63.4	26,676	72.7
50+	2,139	12.1	5,302	14.5
Unk	11	0.1	0	0.0
TOTAL	17,721	100.0	36,685	100.0
Race/Ethnicity				
White	5,158	29.1	8,669	23.6
Black	6,498	36.7	15,085	41.1
Hispanic	5,308	30.0	12,211	33.3
Asian/Pi	258	1.5	470	1.3
Native Am	18	0.1	25	0.1
Multi Race	9	0.1	9	0.0
Other/Unk	472	2.7	216	0.6
TOTAL	17,721	100.0	36,685	100.0
Risk				
MSM	7,692	43.4	13,542	36.9
IDU	1,882	10.6	10,074	27.5
MSM/IDU	300	1.7	1,010	2.8
Heterosexual	1,269	7.2	2,540	6.9
Blood Prod.	40	0.2	139	0.4
Pediatric Risk	621	3.5	399	1.1
Other/Unk	5,917	33.4	8,981	24.5
TOTAL	17,721	100.0	36,685	100.0

*Cases reported and confirmed through June 2005

Table 6B

Newly Diagnosed HIV/AIDS Cases (including prisoners) by Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004 *

	Incubity		Initial AIDS		
	Number	Percent	Number	Percent	
Age Group	12 & under	6	0.4	3	0.1
	13-19	70	4.2	25	0.9
	20-24	181	10.8	94	3.3
	25-29	215	12.8	164	5.8
	30-49	981	58.6	1,933	68.1
	50+	222	13.3	618	21.8
	TOTAL	1,675	100.0	2,837	100.0
Race/Ethnicity	White	370	22.1	544	19.2
	Black	725	43.3	1,288	45.4
	Hispanic	533	31.8	932	32.9
	Asian/Pf	31	1.9	51	1.8
	Native Am	1	0.1	3	0.1
	Multi Race	2	0.1	1	0.0
	Other/Unk	13	0.8	18	0.6
Risk	TOTAL	1,675	100.0	2,837	100.0
	MSM	829	49.5	1,026	36.2
	IDU	141	8.4	414	14.6
	MSM/IDU	21	1.3	69	2.4
	Heterosexual	151	9.0	260	9.2
	Blood Prod	5	0.3	12	0.4
	Pediatric Risk	5	0.3	7	0.2
	Other/Unk	523	31.2	1,049	37.0
	TOTAL	1,675	100.0	2,837	100.0

*Cases reported and confirmed through June 2005

Table 6C

Living HIV/AIDS Cases (including prisoners) by Age, Race/Ethnicity and Risk
Diagnosed through June 2004 *

Age Group	Living HIV		Living AIDS		
	Number	Percent	Number	Percent	
12 & under	757	7.7	369	2.3	
13-19	312	3.2	232	1.5	
20-24	817	8.3	651	4.1	
25-29	1,179	12.0	1,697	10.8	
30-49	5,741	58.5	10,955	69.7	
50+	996	10.2	1,804	11.5	
Unk	9	0.1	0	0.0	
TOTAL	9,811	100.0	15,708	100.0	
Race/Ethnicity	White	755	7.7	1,553	9.9
	Black	5,808	59.2	8,907	56.7
	Hispanic	2,963	30.2	5,073	32.3
	Asian/Pf	81	0.8	102	0.6
	Native Am	11	0.1	6	0.0
	Multi Race	2	0.0	1	0.0
	Other/Unk	191	1.9	66	0.4
TOTAL	9,811	100.0	15,708	100.0	
Risk	IDU	1,130	11.5	4,593	29.2
	Heterosexual	2,896	29.5	5,184	33.0
	Blood Prod.	66	0.7	161	1.0
	Pediatric Risk	642	6.5	406	2.6
	Other/Unk	5,077	51.7	5,364	34.1
TOTAL	9,811	100.0	15,708	100.0	

*Cases reported and confirmed through June 2005

Table 6D

Newly Diagnosed HIV/AIDS Cases (including prisoners) by Age, Race/Ethnicity and Risk Diagnosed July 2003 - June 2004*

Age Group	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
12 & under	8	1.0	4	0.3
13-19	38	4.7	18	1.3
20-24	93	11.4	53	3.7
25-29	88	10.8	109	7.7
30-49	488	59.7	946	66.5
50+	102	12.5	292	20.5
TOTAL	817	100.0	1,422	100.0
Race/Ethnicity	43	5.3	89	6.3
White	544	66.6	901	63.4
Black	206	25.2	407	28.6
Hispanic	11	1.3	18	1.3
Asian/PI	5	0.6	0	0.0
Native Am	1	0.1	0	0.0
Multi Race	7	0.9	7	0.5
Other/Unk	817	100.0	1,422	100.0
Risk	71	8.7	225	15.8
IDU	239	29.3	417	29.3
Heterosexual	7	0.9	16	1.1
Blood Prod.	5	0.6	6	0.4
Pediatric Risk	495	60.6	758	53.3
Other/Unk	817	100.0	1,422	100.0

*Cases reported and confirmed through June 2005

Table 7A

Living HIV/AIDS Cases (excluding prisoners) by Age, Race/Ethnicity and Risk Diagnosed through June 2004*

Age Group	Living HIV		Living AIDS	
	Number	Percent	Number	Percent
12 & under	121	3.3	58	0.8
13-19	92	2.5	66	0.9
20-24	275	7.6	181	2.4
25-29	437	12.0	658	8.6
30-49	2,263	62.1	5,718	74.5
50+	380	10.4	992	12.9
Unk	74	2.0	0	0.0
TOTAL	3,642	100.0	7,673	100.0
Race/Ethnicity	1,707	46.9	3,359	43.8
White	1,298	35.6	2,957	38.5
Black	558	15.3	1,251	16.3
Hispanic	20	0.5	30	0.4
Asian/PI	13	0.4	19	0.2
Native Am	22	0.6	43	0.6
Multi Race	24	0.7	14	0.2
Other/Unk	3,642	100.0	7,673	100.0
Risk	1,685	46.3	3,050	39.7
MSM	670	18.4	2,216	28.9
IDU	134	3.7	410	5.3
MSM/IDU	368	10.1	630	8.2
Heterosexual	28	0.8	90	1.2
Blood Prod.	84	2.3	73	1.0
Pediatric Risk	673	18.5	1,204	15.7
Other/Unk	3,642	100.0	7,673	100.0

*Cases reported and confirmed through June 2005

Table 7B

Newly Diagnosed HIV/AIDS Cases (excluding prisoners) by Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004*

Age Group	Living HIV		Total AIDS	
	Number	Percent	Number	Percent
12 & under	1	0.3	1	0.2
13-19	17	4.8	8	1.3
20-24	44	12.5	17	2.8
25-29	33	9.4	44	7.2
30-49	202	57.5	397	65.0
50+	54	15.4	144	23.6
TOTAL	351	100.0	611	100.0
Race/Ethnicity				
White	118	33.6	244	39.9
Black	165	47.0	250	40.9
Hispanic	52	14.8	112	18.3
Asian/PI	0	0.0	2	0.3
Native Am	2	0.6	1	0.2
Multi Race	13	3.7	2	0.3
Other/Unk	1	0.3	0	0.0
TOTAL	351	100.0	611	100.0
Risk				
MSM	151	43.0	242	39.6
IDU	41	11.7	108	17.7
MSM/IDU	8	2.3	16	2.6
Heterosexual	32	9.1	76	12.4
Blood Prod.	3	0.9	8	1.3
Pediatric Risk	2	0.6	3	0.5
Other/Unk	114	32.5	158	25.9
TOTAL	351	100.0	611	100.0

*Cases reported and confirmed through June 2005

Table 7C

Living HIV/AIDS Cases (excluding prisoners)
by Age, Race/Ethnicity and Risk Diagnosed through June 2004*

Age Group	Living HIV		Living AIDS	
	Number	Percent	Number	Percent
12 & under	132	5.6	53	1.6
13-19	125	5.3	57	1.7
20-24	249	10.5	139	4.1
25-29	344	14.6	424	12.4
30-49	1,294	54.8	2,446	71.5
50+	179	7.6	300	8.8
Unk	39	1.7	0	0.0
TOTAL	2,362	100.0	3,419	100.0
Race/Ethnicity				
White	749	31.7	1,017	29.7
Black	1,190	50.4	1,803	52.7
Hispanic	373	15.8	547	16.0
Asian/PI	10	0.4	10	0.3
Native Am	9	0.4	11	0.3
Multi Race	22	0.9	24	0.7
Other/Unk	9	0.4	7	0.2
TOTAL	2,362	100.0	3,419	100.0
Risk				
IDU	438	18.5	1,010	29.5
Heterosexual	1,173	49.7	1,574	46.0
Blood Prod.	13	0.6	39	1.1
Pediatric Risk	91	3.9	54	1.6
Other/Unk	647	27.4	742	21.7
TOTAL	2,362	100.0	3,419	100.0

*Cases reported and confirmed through June 2005

Table 7D
Newly Diagnosed HIV/AIDS Cases (excluding prisoners) by Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004*

	Initiatives		Initial AIDS		
	Number	Percent	Number	Percent	
Age Group	12 & under	4	1.9	0	0.0
	13-19	15	7.1	2	0.7
	20-24	21	9.9	8	2.8
	25-29	30	14.2	25	8.7
	30-49	104	49.1	207	71.9
	50+	37	17.5	46	16.0
	Unk	1	0.5	0	0.0
	TOTAL	212	100.0	288	100.0
Race/Ethnicity	White	54	25.5	81	28.1
	Black	112	52.8	159	55.2
	Hispanic	33	15.6	38	13.2
	Asian/P1	2	0.9	2	0.7
	Native Am	1	0.5	4	1.4
	Multi Race	10	4.7	4	1.4
	TOTAL	212	100.0	288	100.0
	Risk	IDU	16	7.5	57
Heterosexual		88	41.5	123	42.7
Blood Prod.		3	1.4	4	1.4
Pediatric Risk		3	1.4	1	0.3
Other/Unk		102	48.1	103	35.8
TOTAL	212	100.0	288	100.0	

*Cases reported and confirmed through June 2005

Table 8A
Living HIV/AIDS Cases*
Diagnosed through June 2004*

	HIV		AIDS			
	Number	Percent	Number	Percent		
MALES	13-19	18	0.8	7	0.2	
	20-24	96	4.3	75	2.6	
	25-29	249	11.2	315	10.8	
	30-49	1,601	71.8	2,325	79.8	
	50+	261	11.7	190	6.5	
	Unk	5	0.2	0	0.0	
	TOTAL	2,230	100.0	2,912	100.0	
	Race/Ethnicity	White	172	7.7	224	7.7
		Black	1,011	45.3	1,371	47.1
		Hispanic	1,024	45.9	1,289	44.3
		Asian/P1	3	0.1	4	0.1
		Native Am	5	0.2	7	0.2
		Multi Race	13	0.6	14	0.5
		Other/Unk	2	0.1	3	0.1
	TOTAL	2,230	100.0	2,912	100.0	
FEMALES	13-19	4	0.7	2	0.5	
	20-24	32	5.3	11	2.7	
	25-29	71	11.9	61	14.7	
	30-49	439	73.3	326	78.6	
	50+	51	8.5	15	3.6	
	Unk	2	0.3	0	0.0	
	TOTAL	599	100.0	415	100.0	
	Race/Ethnicity	White	62	10.4	26	6.3
		Black	294	49.1	246	59.3
		Hispanic	239	39.9	141	34.0
		Native Am	2	0.3	1	0.2
		Multi Race	1	0.2	0	0.0
		Other/Unk	1	0.2	1	0.2
	TOTAL	599	100.0	415	100.0	

*Cases reported and confirmed through June 2005

Table 8B
Newly Diagnosed HIV/AIDS Cases* by Gender, Age, and Race/Ethnicity
Diagnosed July 2003- June 2004*

Gender		Initial HIV		Initial AIDS	
		Number	Percent	Number	Percent
Male		19	73.1	142	83.5
Female		7	26.9	28	16.5
TOTAL		26	100.0	170	100.0
Age Group	20-24	1	3.8	1	0.6
	25-29	4	15.4	16	9.4
	30-49	20	76.9	127	74.7
	50+	1	3.8	26	15.3
	TOTAL	26	100.0	170	100.0
Race/Ethnicity	White	2	7.7	12	7.1
	Black	14	53.8	89	52.4
	Hispanic	6	23.1	60	35.3
	Asian/Pi	0	0.0	1	0.6
	Native Am	0	0.0	2	1.2
	Multi Race	4	15.4	6	3.5
	TOTAL	26	100.0	170	100.0

*Cases reported and confirmed through June 2005

Table 9A
Living HIV/AIDS Cases* Diagnosed through June 2004

INCLUDES PRISONERS	Ryan White Region	Living HIV		Cumulative AIDS	
		Albany	Living HIV	Albany	Cumulative AIDS
	Binghamton		140	177	356
	Buffalo		1,222	1,539	3,204
	Lower Hudson		1,244	2,754	6,088
	Mid Hudson		1,118	1,957	4,396
	Nassau/Suffolk		1,447	3,053	7,591
	Rochester		1,049	1,382	2,895
	Syracuse		1,169	1,644	3,213
	Unk		0	0	1
	TOTAL		8,834	14,419	31,709
EXCLUDES PRISONERS	Albany		820	1,146	2,485
	Binghamton		132	165	337
	Buffalo		709	1,028	2,334
	Lower Hudson		973	2,409	5,531
	Mid Hudson		649	1,281	3,059
	Nassau/Suffolk		1,405	3,002	7,486
	Rochester		774	1,162	2,513
	Syracuse		543	899	1,931
	Unk		0	0	1
	TOTAL		6,005	11,092	25,677

*Cases reported and confirmed through June 2005

NEW YORK STATE (Excluding NYC) by Ryan White Region

Table 9B
Newly Diagnosed HIV/AIDS Cases*
Diagnosed July 2003 - June 2004

	Ryan White Region	Initial HIV	Initial AIDS
INCLUDES PRISONERS	Albany	91	144
	Binghamton	6	18
	Buffalo	62	118
	Lower Hudson	107	192
	Mid Hudson	68	163
	Nassau/Suffolk	142	227
	Rochester	76	105
	Syracuse	37	102
	TOTAL	589	1,069
EXCLUDES PRISONERS	Albany	82	115
	Binghamton	6	18
	Buffalo	60	96
	Lower Hudson	102	169
	Mid Hudson	62	116
	Nassau/Suffolk	142	222
	Rochester	73	87
	Syracuse	36	76
	TOTAL	563	899

Page 33

RYAN WHITE REGION: ALBANY

(Includes counties of: Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schoenectady, Warren, Washington)

Page 34

Table 10A
HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

	Living HIV**		AIDS***	
	Number	Percent	Number	Percent
Gender				
Male	492	60.0	802	70.0
Female	328	40.0	344	30.0
TOTAL	820	100.0	1,146	100.0
Age Group				
12 & under	32	3.9	12	1.0
13-19	34	4.1	11	1.0
20-24	97	11.8	30	2.6
25-29	136	16.6	137	12.0
30-49	456	55.6	844	73.6
50+	62	7.6	112	9.8
Unk	3	0.4	0	0.0
TOTAL	820	100.0	1,146	100.0
Race/Ethnicity				
White	424	51.7	565	49.3
Black	291	35.5	427	37.3
Hispanic	87	10.6	143	12.5
Asian/P1	5	0.6	4	0.3
Native Am	5	0.6	2	0.2
Multi Race	3	0.4	3	0.3
Other/Unk	5	0.6	2	0.2
TOTAL	820	100.0	1,146	100.0
Risk				
MSM	272	33.2	368	32.1
IDU	122	14.9	280	24.4
MSM/IDU	19	2.3	36	3.1
Heterosexual	187	22.8	185	16.1
Blood Prod.	8	1.0	13	1.1
Pediatric Risk	20	2.4	12	1.0
Other/Unk	192	23.4	252	22.0
TOTAL	820	100.0	1,146	100.0

*Excludes Prisoners

**All cases reported and confirmed from June 2000 - June 2005
***All cases reported and confirmed from 1983 - June 2005

*Cases reported and confirmed through June 2005

Table 10B

Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	39	47.6	80	69.6
Female	43	52.4	35	30.4
TOTAL	82	100.0	115	100.0
Age Group				
12 & under	1	1.2	0	0.0
13-19	7	8.5	0	0.0
20-24	5	6.1	0	0.0
25-29	9	11.0	12	10.4
30-49	48	58.5	75	65.2
50+	12	14.6	28	24.3
TOTAL	82	100.0	115	100.0
Race/Ethnicity				
White	32	39.0	52	45.2
Black	40	48.8	50	43.5
Hispanic	5	6.1	13	11.3
Multi Race	5	6.1	0	0.0
TOTAL	82	100.0	115	100.0
Risk				
MSM	18	22.0	42	36.5
IDU	7	8.5	19	16.5
MSM/IDU	1	1.2	2	1.7
Heterosexual	27	32.9	22	19.1
Blood Prod.	1	1.2	1	0.9
Pediatric Risk	1	1.2	0	0.0
Other/Unk	27	32.9	29	25.2
TOTAL	82	100.0	115	100.0

*Excludes Prisoners

Cases reported and confirmed through June 2005

Table 11A

HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

	Living HIV**		Living AIDS***		Cumulative	
	Number	Percent	Number	Percent	Number	Percent
Gender						
Male	82	62.1	114	69.1	255	75.7
Female	50	37.9	51	30.9	82	24.3
TOTAL	132	100.0	165	100.0	337	100.0
Age Group						
12 & under	7	5.3	0	0.0	1	0.3
13-19	3	2.3	2	1.2	4	1.2
20-24	14	10.6	6	3.6	12	3.6
25-29	21	15.9	10	6.1	37	11.0
30-49	81	61.4	129	78.2	248	73.6
50+	6	4.5	18	10.9	35	10.4
TOTAL	132	100.0	165	100.0	337	100.0
Race/Ethnicity						
White	75	56.8	98	59.4	228	67.7
Black	36	27.3	47	28.5	77	22.8
Hispanic	20	15.2	19	11.5	31	9.2
Native Am	0	0.0	1	0.6	1	0.3
Other/Unk	1	0.8	0	0.0	0	0.0
TOTAL	132	100.0	165	100.0	337	100.0
Risk						
MSM	28	21.2	60	36.4	141	41.8
IDU	33	25.0	39	23.6	81	24.0
MSM/IDU	5	3.8	5	3.0	20	5.9
Heterosexual	22	16.7	19	11.5	35	10.4
Blood Prod.	0	0.0	2	1.2	4	1.2
Pediatric Risk	7	5.3	1	0.6	4	1.2
Other/Unk	37	28.0	39	23.6	52	15.4
TOTAL	132	100.0	165	100.0	337	100.0

*Excludes Prisoners

**All cases reported and confirmed from June 2000 - June 2005

***All cases reported and confirmed from 1983 - June 2005

RYAN WHITE REGION: BINGHAMTON
(Includes counties of: Broome, Chenango, Tioga)

Page 37

Table 11B
Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	6	100.0	13	72.2
Female	0	0.0	5	27.8
TOTAL	6	100.0	18	100.0
Age Group				
20-24	2	33.3	0	0.0
25-29	1	16.7	1	5.6
30-49	2	33.3	15	83.3
50+	1	16.7	2	11.1
TOTAL	6	100.0	18	100.0
Race/Ethnicity				
White	4	66.7	9	50.0
Black	2	33.3	5	27.8
Hispanic	0	0.0	4	22.2
TOTAL	6	100.0	18	100.0
Risk				
MSM	2	33.3	5	27.8
IDU	0	0.0	3	16.7
MSM/IDU	1	16.7	0	0.0
Heterosexual	0	0.0	2	11.1
Other/Unk	3	50.0	8	44.4
TOTAL	6	100.0	18	100.0

*Excludes Prisoners
Cases reported and confirmed through June 2005

RYAN WHITE REGION: BUFFALO
(Includes counties of: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming)

Page 38

Table 12A
HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

	Living HIV**		AIDS***	
	Number	Percent	Number	Percent
Gender				
Male	432	60.9	753	73.2
Female	277	39.1	275	26.8
TOTAL	709	100.0	1,028	100.0
Age Group				
12 & under	17	2.4	5	0.5
13-19	43	6.1	16	1.6
20-24	90	12.7	41	4.0
25-29	117	16.5	103	10.0
30-49	398	56.1	735	71.5
50+	44	6.2	128	12.5
TOTAL	709	100.0	1,028	100.0
Race/Ethnicity				
White	271	38.2	407	39.6
Black	315	44.4	462	44.9
Hispanic	109	15.4	132	12.8
Asian/PI	4	0.6	6	0.6
Native Am	1	0.1	9	0.9
Multi Race	7	1.0	9	0.9
Other/Unk	2	0.3	3	0.3
TOTAL	709	100.0	1,028	100.0
Risk				
MSM	243	34.3	414	40.3
IDU	134	18.9	230	22.4
MSM/IDU	20	2.8	46	4.5
Heterosexual	233	32.9	246	23.9
Blood Prod.	4	0.6	12	1.2
Pediatric Risk	15	2.1	9	0.9
Other/Unk	60	8.5	71	6.9
TOTAL	709	100.0	1,028	100.0

*Excludes Prisoners
**All cases reported and confirmed from June 2000 - June 2005
***All cases reported and confirmed from 1983 - June 2005

RYAN WHITE REGION: BUFFALO

(Includes counties of: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming)

Page 39

Page 40

Table 12B

**Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004**

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	40	66.7	67	69.8
Female	20	33.3	29	30.2
TOTAL	60	100.0	96	100.0
Age Group				
13-19	5	8.3	1	1.0
20-24	15	25.0	3	3.1
25-29	5	8.3	9	9.4
30-49	26	43.3	66	68.8
50+	9	15.0	17	17.7
TOTAL	60	100.0	96	100.0
Race/Ethnicity				
White	18	30.0	29	30.2
Black	32	53.3	51	53.1
Hispanic	5	8.3	14	14.6
Asian/PI	1	1.7	1	1.0
Native Am	0	0.0	1	1.0
Multi Race	4	6.7	0	0.0
TOTAL	60	100.0	96	100.0
Risk				
MSM	22	36.7	28	29.2
IDU	5	8.3	16	16.7
MSM/IDU	3	5.0	5	5.2
Heterosexual	12	20.0	34	35.4
Blood Prod.	0	0.0	1	1.0
Pediatric Risk	0	0.0	1	1.0
Other/Unk	18	30.0	11	11.5
TOTAL	60	100.0	96	100.0

*Excludes Prisoners

Cases reported and confirmed through June 2005

Table 13A

**HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004**

	Living HIV**		Living AIDS***	
	Number	Percent	Number	Percent
Gender				
Male	565	58.1	1,595	66.2
Female	407	41.8	814	33.8
Unk	1	0.1	0	0.0
TOTAL	973	100.0	2,409	100.0
Age Group				
12 & under	43	4.4	30	1.2
13-19	24	2.5	30	1.2
20-24	73	7.5	51	2.1
25-29	84	8.6	199	8.3
30-49	568	58.4	1,803	74.8
50+	131	13.5	296	12.3
Unk	50	5.1	0	0.0
TOTAL	973	100.0	2,409	100.0
Race/Ethnicity				
White	266	27.3	625	25.9
Black	497	51.1	1,255	52.1
Hispanic	196	20.1	494	20.5
Asian/PI	3	0.3	3	0.1
Native Am	0	0.0	4	0.2
Multi Race	9	0.9	21	0.9
Other/Unk	2	0.2	7	0.3
TOTAL	973	100.0	2,409	100.0
Risk				
MSM	199	20.5	494	20.5
IDU	189	19.4	879	36.5
MSM/IDU	17	1.7	81	3.4
Heterosexual	339	34.8	641	26.6
Blood Prod	7	0.7	16	0.7
Pediatric Risk	32	3.3	32	1.3
Other/Unk	190	19.5	266	11.0
TOTAL	973	100.0	2,409	100.0

*Excludes Prisoners

**All cases reported and confirmed from June 2000 - June 2005

***All cases reported and confirmed from 1983 - June 2005

RYAN WHITE REGION: LOWER HUDSON
(Includes counties of: Putnam, Rockland, Westchester)

Table 13B
Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	64	62.7	112	66.3
Female	38	37.3	57	33.7
TOTAL	102	100.0	169	100.0
Age Group				
13-19	4	3.9	4	2.4
20-24	12	11.8	5	3.0
25-29	12	11.8	7	4.1
30-49	53	52.0	118	69.8
50+	20	19.6	35	20.7
Unk	1	1.0	0	0.0
TOTAL	102	100.0	169	100.0
Race/Ethnicity				
White	21	20.6	39	23.1
Black	51	50.0	88	52.1
Hispanic	26	25.5	39	23.1
Native Am	1	1.0	1	0.6
Multi Race	3	2.9	2	1.2
TOTAL	102	100.0	169	100.0
Risk				
MSM	24	23.5	35	20.7
IDU	13	12.7	38	22.5
MSM/IDU	1	1.0	2	1.2
Heterosexual	22	21.6	55	32.5
Blood Prod.	2	2.0	0	0.0
Pediatric Risk	0	0.0	2	1.2
Other/Unk	40	39.2	37	21.9
TOTAL	102	100.0	169	100.0

*Excludes Prisoners
Cases reported and confirmed through June 2005

RYAN WHITE REGION: MID-HUDSON
(Includes counties of: Dutchess, Orange, Sullivan, Ulster)

Table 14A
HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

	Living HIV**		Living AIDS***	
	Number	Percent	Number	Percent
Gender				
Male	383	59.0	888	69.3
Female	266	41.0	393	30.7
TOTAL	649	100.0	1,281	100.0
Age Group				
12 & under	28	4.3	15	1.2
13-19	14	2.2	14	1.1
20-24	40	6.2	31	2.4
25-29	49	7.6	108	8.4
30-49	419	64.6	949	74.1
50+	69	10.6	164	12.8
Unk	30	4.6	0	0.0
TOTAL	649	100.0	1,281	100.0
Race/Ethnicity				
White	279	43.0	474	37.0
Black	249	38.4	514	40.1
Hispanic	111	17.1	281	21.9
Asian/Pi	3	0.5	0	0.0
Native Am	2	0.3	2	0.2
Multi Race	5	0.8	7	0.5
Other/Unk	0	0.0	3	0.2
TOTAL	649	100.0	1,281	100.0
Risk				
MSM	133	20.5	240	18.7
IDU	192	29.6	507	39.6
MSM/IDU	16	2.5	42	3.3
Heterosexual	203	31.3	297	23.2
Blood Prod.	4	0.6	9	0.7
Pediatric Risk	25	3.9	16	1.2
Other/Unk	76	11.7	170	13.3
TOTAL	649	100.0	1,281	100.0

*Excludes Prisoners
**All cases reported and confirmed from June 2000 - June 2005
***All cases reported and confirmed from 1983 - June 2005

Table 14B
Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	34	54.8	80	69.0
Female	28	45.2	36	31.0
TOTAL	62	100.0	116	100.0
Age Group				
13-19	2	3.2	3	2.6
20-24	4	6.5	1	0.9
25-29	5	8.1	9	7.8
30-49	39	62.9	71	61.2
50+	12	19.4	32	27.6
TOTAL	62	100.0	116	100.0
Race/Ethnicity				
White	22	35.5	46	39.7
Black	24	38.7	49	42.2
Hispanic	13	21.0	21	18.1
Native Am	1	1.6	0	0.0
Multi Race	2	3.2	0	0.0
TOTAL	62	100.0	116	100.0
Risk				
MSM	13	21.0	26	22.4
IDU	10	16.1	26	22.4
MSM/IDU	0	0.0	1	0.9
Heterosexual	19	30.6	35	30.2
Blood Prod.	1	1.6	1	0.9
Other/Unk	19	30.6	27	23.3
TOTAL	62	100.0	116	100.0

*Excludes Prisoners
Cases reported and confirmed through June 2005

Table 15A
HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

	Living HIV**		Living AIDS***	
	Number	Percent	Number	Percent
Gender				
Male	821	58.4	2,071	69.0
Female	584	41.6	931	31.0
TOTAL	1,405	100.0	3,002	100.0
Age Group				
12 & under	95	6.8	37	1.2
13-19	45	3.2	37	1.2
20-24	94	6.7	93	3.1
25-29	165	11.7	264	8.8
30-49	848	60.4	2,191	73.0
50+	130	9.3	380	12.7
Unk	28	2.0	0	0.0
TOTAL	1,405	100.0	3,002	100.0
Race/Ethnicity				
White	543	38.6	1,239	41.3
Black	581	41.4	1,237	41.2
Hispanic	242	17.2	483	16.1
Asian/Pi	11	0.8	17	0.6
Native Am	6	0.4	6	0.2
Multi Race	7	0.5	16	0.5
Other/Unk	15	1.1	4	0.1
TOTAL	1,405	100.0	3,002	100.0
Risk				
MSM	362	25.8	795	26.5
IDU	212	15.1	806	26.8
MSM/IDU	27	1.9	125	4.2
Heterosexual	294	20.9	477	15.9
Blood Prod.	14	1.0	43	1.4
Pediatric Risk	55	3.9	39	1.3
Other/Unk	441	31.4	717	23.9
TOTAL	1,405	100.0	3,002	100.0

*Excludes Prisoners
**All cases reported and confirmed from June 2000 - June 2005
***All cases reported and confirmed from 1983 - June 2005

RYAN WHITE REGION: NASSAU/SUFFOLK
(Includes counties of: Nassau, Suffolk)

Page 45

Table 15B
Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	91	64.1	141	63.5
Female	51	35.9	81	36.5
TOTAL	142	100.0	222	100.0
Age Group				
12 & under	2	1.4	1	0.5
13-19	10	7.0	2	0.9
20-24	15	10.6	11	5.0
25-29	18	12.7	16	7.2
30-49	77	54.2	143	64.4
50+	20	14.1	49	22.1
TOTAL	142	100.0	222	100.0
Race/Ethnicity				
White	41	28.9	75	33.8
Black	70	49.3	99	44.6
Hispanic	28	19.7	43	19.4
Asian/PI	1	0.7	2	0.9
Native Am	1	0.7	1	0.5
Multi Race	1	0.7	2	0.9
TOTAL	142	100.0	222	100.0
Risk				
MSM	43	30.3	54	24.3
IDU	12	8.5	36	16.2
MSM/IDU	0	0.0	2	0.9
Heterosexual	19	13.4	25	11.3
Blood Prod.	2	1.4	6	2.7
Pediatric Risk	2	1.4	1	0.5
Other/Unk	64	45.1	98	44.1
TOTAL	142	100.0	222	100.0

*Excludes Prisoners
Cases reported and confirmed through June 2005

RYAN WHITE REGION: ROCHESTER
(Includes counties of: Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates)

Page 46

Table 16A
HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

	Living HIV**		AIDS***	
	Number	Percent	Number	Percent
Gender				
Male	524	67.7	807	69.4
Female	250	32.3	355	30.6
TOTAL	774	100.0	1,162	100.0
Age Group				
12 & under	13	1.7	8	0.7
13-19	24	3.1	4	0.3
20-24	61	7.9	22	1.9
25-29	126	16.3	153	13.2
30-49	471	60.9	862	74.2
50+	79	10.2	113	9.7
TOTAL	774	100.0	1,162	100.0
Race/Ethnicity				
White	320	41.3	499	42.9
Black	331	42.8	492	42.3
Hispanic	108	14.0	159	13.7
Asian/PI	0	0.0	3	0.3
Native Am	4	0.5	1	0.1
Multi Race	8	1.0	7	0.6
Other/Unk	3	0.4	1	0.1
TOTAL	774	100.0	1,162	100.0
Risk				
MSM	270	34.9	350	30.1
IDU	136	17.6	308	26.5
MSM/IDU	16	2.1	38	3.3
Heterosexual	116	15.0	150	12.9
Blood Prod.	2	0.3	14	1.2
Pediatric Risk	8	1.0	10	0.9
Other/Unk	226	29.2	292	25.1
TOTAL	774	100.0	1,162	100.0

*Excludes Prisoners
**All cases reported and confirmed from June 2000 - June 2005
***All cases reported and confirmed from 1983 - June 2005

RYAN WHITE REGION: ROCHESTER

(Includes counties of: Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates)

Page 47

Table 16B

**Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004**

Gender	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Male	53	72.6	69	79.3
Female	20	27.4	18	20.7
TOTAL	73	100.0	87	100.0
Age Group				
12 & under	1	1.4	0	0.0
13-19	1	1.4	0	0.0
20-24	6	8.2	2	2.3
25-29	5	6.8	6	6.9
30-49	48	65.8	63	72.4
50+	12	16.4	16	18.4
TOTAL	73	100.0	87	100.0
Race/Ethnicity				
White	20	27.4	41	47.1
Black	39	53.4	32	36.8
Hispanic	6	8.2	13	14.9
Asian/PI	0	0.0	1	1.1
Multi Race	7	9.6	0	0.0
Other/Unk	1	1.4	0	0.0
TOTAL	73	100.0	87	100.0
Risk				
MSM	18	24.7	24	27.6
IDU	8	11.0	16	18.4
MSM/IDU	0	0.0	2	2.3
Heterosexual	10	13.7	7	8.0
Blood Prod.	0	0.0	2	2.3
Other/Unk	37	50.7	36	41.4
TOTAL	73	100.0	87	100.0

*Excludes Prisoners

Cases reported and confirmed through June 2005

RYAN WHITE REGION: SYRACUSE

(Includes counties of: Cayuga, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St Lawrence, Tompkins)

Page 48

Table 17A

**HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004**

	Living HIV		Living AIDS		Cumulative	
	Number	Percent	Number	Percent	Number	Percent
Gender						
Male	343	63.2	643	71.3	1,502	77.8
Female	200	36.8	256	28.5	429	22.2
TOTAL	543	100.0	899	100.0	1,931	100.0
Age Group						
12 & under	18	3.3	4	0.4	12	0.6
13-19	30	5.5	9	1.0	21	1.1
20-24	55	10.1	46	5.1	81	4.2
25-29	83	15.3	108	12.0	250	12.9
30-49	317	58.4	651	72.4	1,388	71.9
50+	38	7.0	81	9.0	179	9.3
Unk	2	0.4	0	0.0	0	0.0
TOTAL	543	100.0	899	100.0	1,931	100.0
Race/Ethnicity						
White	278	51.2	469	52.2	1,136	58.8
Black	189	34.8	326	36.3	607	31.4
Hispanic	58	10.7	87	9.7	169	8.8
Asian/PI	4	0.7	7	0.8	7	0.4
Native Am	4	0.7	5	0.6	6	0.3
Multi Race	5	0.9	4	0.4	5	0.3
Other/Unk	5	0.9	1	0.1	1	0.1
TOTAL	543	100.0	899	100.0	1,931	100.0
Risk						
MSM	178	32.8	329	36.6	794	41.1
IDU	90	16.6	177	19.7	453	23.5
MSM/IDU	14	2.6	37	4.1	104	5.4
Heterosexual	147	27.1	189	21.0	293	15.2
Blood Prod.	2	0.4	20	2.2	60	3.1
Pediatric Risk	13	2.4	8	0.9	20	1.0
Other/Unk	99	18.2	139	15.5	207	10.7
TOTAL	543	100.0	899	100.0	1,931	100.0

*Excludes Prisoners

**All cases reported and confirmed from June 2000 - June 2005

***All cases reported and confirmed from 1983 - June 2005

RYAN WHITE REGION: SYRACUSE
(Includes counties of: Cayuga, Cortland, Herkimer, Jefferson, Lewis, Madison,
Oneida, Onondaga, Oswego, St. Lawrence, Tompkins)

Page 49

Table 17B
Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	24	66.7	49	64.5
Female	12	33.3	27	35.5
TOTAL	36	100.0	76	100.0
Age Group				
12 & under	1	2.8	0	0.0
13-19	3	8.3	0	0.0
20-24	6	16.7	3	3.9
25-29	8	22.2	9	11.8
30-49	13	36.1	53	69.7
50+	5	13.9	11	14.5
TOTAL	36	100.0	76	100.0
Race/Ethnicity				
White	14	38.9	34	44.7
Black	19	52.8	35	46.1
Hispanic	2	5.6	3	3.9
Native Am	0	0.0	2	2.6
Multi Race	1	2.8	2	2.6
TOTAL	36	100.0	76	100.0
Risk				
MSM	11	30.6	28	36.8
IDU	2	5.6	11	14.5
MSM/IDU	2	5.6	2	2.6
Heterosexual	11	30.6	19	25.0
Blood Prod.	0	0.0	1	1.3
Pediatric Risk	2	5.6	0	0.0
Other/Unk	8	22.2	15	19.7
TOTAL	36	100.0	76	100.0

*Excludes Prisoners
Cases reported and confirmed through June 2005

NEW YORK CITY: by Borough

Page 50

Table 18A
HIV/AIDS Cases Diagnosed through June 2004

Borough	Living HIV*		AIDS**	
	Living	Cumulative	Living	Cumulative
Bronx	6,843	11,680	28,049	
Brooklyn	6,984	14,115	35,634	
Manhattan	9,841	17,441	47,237	
Queens	3,513	8,145	18,694	
Staten Island	571	1,012	2,737	
TOTAL	27,752	52,393	132,371	

*All cases reported and confirmed from June 2000 - June 2005
**All cases reported and confirmed from 1983 - June 2005

Table 18B

Newly Diagnosed HIV/AIDS Cases*
Diagnosed July 2003 - June 2004

Borough	Initial HIV	Initial AIDS
Bronx	664	1,035
Brooklyn	651	1,178
Manhattan	788	1,378
Queens	343	607
Staten Island	46	61
TOTAL	2,492	4,259

Table 19A

HIV/AIDS Cases by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

		Living HIV*		Living AIDS**		Cumulative	
		Number	Percent	Number	Percent	Number	Percent
Gender	Male	3,392	52.5	7,282	62.3	18,510	66.0
	Female	3,249	47.5	4,398	37.7	9,539	34.0
	Unk	2	0.0	0	0.0	0	0.0
	TOTAL	6,843	100.0	11,680	100.0	28,049	100.0
Age Group	12 & under	546	8.0	216	1.8	586	2.1
	13-19	194	2.8	131	1.1	172	0.6
	20-24	548	8.0	383	3.3	758	2.7
	25-29	759	11.1	1,033	8.8	2,620	9.3
	30-49	4,002	58.5	8,359	71.6	20,051	71.5
	50+	782	11.4	1,558	13.3	3,862	13.8
	Unk	12	0.2	0	0.0	0	0.0
	TOTAL	6,843	100.0	11,680	100.0	28,049	100.0
Race/Ethnicity	White	342	5.0	669	5.7	1,880	6.7
	Black	3,239	47.3	5,056	43.3	11,894	42.4
	Hispanic	3,128	45.7	5,874	50.3	14,143	50.4
	Asian/Pi	23	0.3	37	0.3	81	0.3
	Native Am	7	0.1	5	0.0	9	0.0
	Multi Race	1	0.0	1	0.0	1	0.0
	Other/Unk	103	1.5	38	0.3	41	0.1
	TOTAL	6,843	100.0	11,680	100.0	28,049	100.0
Risk	MSM	824	12.0	1,549	13.3	4,146	14.8
	IDU	1,010	14.8	4,082	34.9	13,293	47.4
	MSM/IDU	76	1.1	259	2.2	811	2.9
	Heterosexual	1,124	16.4	2,126	18.2	4,064	14.5
	Blood Prod.	29	0.4	70	0.6	164	0.6
	Pediatric Risk	479	7.0	253	2.2	622	2.2
	Other/Unk	3,301	48.2	3,341	28.6	4,949	17.6
	TOTAL	6,843	100.0	11,680	100.0	28,049	100.0

* All cases reported and confirmed from June 2000 - June 2005

** All cases reported and confirmed from 1983 - June 2005

* Cases reported and confirmed through June 2005

BOROUGH: BRONX
Table 19B

Newly Diagnosed HIV/AIDS Cases by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004*

		Initial HIV		Initial AIDS	
		Number	Percent	Number	Percent
Gender	Male	404	60.8	610	58.9
	Female	260	39.2	425	41.1
	TOTAL	664	100.0	1,035	100.0
Age Group	12 & under	5	0.8	3	0.3
	13-19	40	6.0	9	0.9
	20-24	81	12.2	35	3.4
	25-29	78	11.7	70	6.8
	30-49	376	56.6	724	70.0
	50+	84	12.7	194	18.7
	TOTAL	664	100.0	1,035	100.0
Race/Ethnicity	White	32	4.8	49	4.7
	Black	326	49.1	513	49.6
	Hispanic	292	44.0	463	44.7
	Asian/PI	2	0.3	3	0.3
	Native Am	3	0.5	1	0.1
	Other/Unk	9	1.4	6	0.6
	TOTAL	664	100.0	1,035	100.0
Risk	MSM	136	20.5	136	13.1
	IDU	77	11.6	215	20.8
	MSM/IDU	10	1.5	18	1.7
	Heterosexual	127	19.1	183	17.7
	Blood Prod.	3	0.5	5	0.5
	Pediatric Risk	3	0.5	5	0.5
	Other/Unk	308	46.4	473	45.7
	TOTAL	664	100.0	1,035	100.0

*Cases reported and confirmed through June 2005

BOROUGH: BROOKLYN
Table 20A

*HIV/AIDS Cases by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004*

		Living HIV		Living AIDS		Cumulative	
		Number	Percent	Number	Percent	Number	Percent
Gender	Male	3,835	54.9	9,036	64.0	24,306	68.2
	Female	2,967	42.5	5,079	36.0	11,328	31.8
	Unk	182	2.6	0	0.0	0	0.0
	TOTAL	6,984	100.0	14,115	100.0	35,634	100.0
Age Group	12 & under	431	6.2	251	1.8	704	2.0
	13-19	205	2.9	162	1.1	232	0.7
	20-24	575	8.2	485	3.4	1,013	2.8
	25-29	850	12.2	1,338	9.5	3,515	9.9
	30-49	4,089	58.5	9,960	70.6	25,224	70.8
	50+	832	11.9	1,919	13.6	4,946	13.9
	Unk	2	0.0	0	0.0	0	0.0
	TOTAL	6,984	100.0	14,115	100.0	35,634	100.0
Race/Ethnicity	White	933	13.4	1,609	11.4	4,859	13.6
	Black	4,199	60.1	8,715	61.7	21,372	60.0
	Hispanic	1,479	21.2	3,614	25.6	9,143	25.7
	Asian/PI	73	1.0	111	0.8	184	0.5
	Native Am	5	0.1	7	0.0	10	0.0
	Multi Race	4	0.1	1	0.0	1	0.0
	Other/Unk	291	4.2	58	0.4	65	0.2
	TOTAL	6,984	100.0	14,115	100.0	35,634	100.0
Risk	MSM	1,352	19.4	2,473	17.5	6,690	18.8
	IDU	824	11.8	3,932	27.9	14,590	40.9
	MSM/IDU	66	0.9	231	1.6	768	2.2
	Heterosexual	1,267	18.1	2,447	17.3	4,590	12.9
	Blood Prod.	27	0.4	95	0.7	280	0.8
	Pediatric Risk	354	5.1	258	1.8	704	2.0
	Other/Unk	3,094	44.3	4,679	33.1	8,012	22.5
	TOTAL	6,984	100.0	14,115	100.0	35,634	100.0

*All cases reported and confirmed from June 2000 - June 2005
**All cases reported and confirmed from 1983 - June 2005

Table 20B

Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	396	60.8	732	62.1
Female	255	39.2	446	37.9
TOTAL	651	100.0	1,178	100.0
Age Group				
12 & under	5	0.8	3	0.3
13-19	30	4.6	16	1.4
20-24	84	12.9	47	4.0
25-29	77	11.8	69	5.9
30-49	360	55.3	774	65.7
50+	95	14.6	269	22.8
TOTAL	651	100.0	1,178	100.0
Race/Ethnicity				
White	57	8.8	119	10.1
Black	464	71.3	786	66.7
Hispanic	113	17.4	255	21.6
Asian/Pi	13	2.0	11	0.9
Native Am	1	0.2	0	0.0
Other/Unk	3	0.5	7	0.6
TOTAL	651	100.0	1,178	100.0
Risk				
MSM	166	25.5	242	20.5
IDU	54	8.3	164	13.9
MSM/IDU	4	0.6	13	1.1
Heterosexual	97	14.9	199	16.9
Blood Prod.	3	0.5	6	0.5
Pediatric Risk	4	0.6	6	0.5
Other/Unk	323	49.6	548	46.5
TOTAL	651	100.0	1,178	100.0

*Cases reported and confirmed through June 2005

Table 21A

HIV/AIDS Cases by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

	Living HIV*		AIDS**	
	Number	Percent	Number	Percent
Gender				
Male	7,705	78.3	13,927	79.9
Female	2,102	21.4	3,514	20.1
Unk	34	0.3	0	0.0
TOTAL	9,841	100.0	17,441	100.0
Age Group				
12 & under	339	3.4	141	0.8
13-19	148	1.5	86	0.5
20-24	592	6.0	384	2.2
25-29	1,141	11.6	1,581	9.1
30-49	6,445	65.5	12,718	72.9
50+	1,173	11.9	2,531	14.5
Unk	3	0.0	0	0.0
TOTAL	9,841	100.0	17,441	100.0
Race/Ethnicity				
White	3,729	37.9	5,977	34.3
Black	3,138	31.9	6,347	36.4
Hispanic	2,416	24.6	4,757	27.3
Asian/Pi	147	1.5	205	1.2
Native Am	13	0.1	7	0.0
Multi Race	2	0.0	6	0.0
Other/Unk	396	4.0	142	0.8
TOTAL	9,841	100.0	17,441	100.0
Risk				
MSM	4,377	44.5	7,237	41.5
IDU	780	7.9	4,173	23.9
MSM/IDU	122	1.2	381	2.2
Heterosexual	948	9.6	1,617	9.3
Blood Prod.	27	0.3	61	0.3
Pediatric Risk	281	2.9	155	0.9
Other/Unk	3,306	33.6	3,817	21.9
TOTAL	9,841	100.0	17,441	100.0

*All cases reported and confirmed from June 2000 - June 2005

**All cases reported and confirmed from 1983 - June 2005

BOROUGH: MANHATTAN

Table 21B

Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	626	79.4	1,049	76.1
Female	162	20.6	329	23.9
TOTAL	788	100.0	1,378	100.0
Age Group				
12 & under	3	0.4	0	0.0
13-19	19	2.4	10	0.7
20-24	77	9.8	32	2.3
25-29	100	12.7	78	5.7
30-49	492	62.4	937	68.0
50+	97	12.3	321	23.3
TOTAL	788	100.0	1,378	100.0
Race/Ethnicity				
White	248	31.5	363	26.3
Black	299	37.9	571	41.4
Hispanic	222	28.2	408	29.6
Asian/P1	13	1.6	25	1.8
Native Am	1	0.1	2	0.1
Multi Race	1	0.1	1	0.1
Other/Unk	4	0.5	8	0.6
TOTAL	788	100.0	1,378	100.0
Risk				
MSM	403	51.1	490	35.6
IDU	55	7.0	176	12.8
MSM/IDU	5	0.6	29	2.1
Heterosexual	85	10.8	178	12.9
Blood Prod.	2	0.3	7	0.5
Pediatric Risk	3	0.4	2	0.1
Other/Unk	235	29.8	496	36.0
TOTAL	788	100.0	1,378	100.0

*Cases reported and confirmed through June 2005
**All cases reported and confirmed from 1983 - June 2005

BOROUGH: QUEENS

Table 22A

HIV/AIDS Cases by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

	Living/HIV		Living		AIDS**	
	Number	Percent	Number	Percent	Number	Percent
Gender						
Male	2,268	64.6	5,779	71.0	14,000	74.9
Female	1,244	35.4	2,366	29.0	4,694	25.1
Unk	1	0.0	0	0.0	0	0.0
TOTAL	3,513	100.0	8,145	100.0	18,694	100.0
Age Group						
12 & under	161	4.6	101	1.2	277	1.5
13-19	84	2.4	74	0.9	99	0.5
20-24	259	7.4	284	3.5	511	2.7
25-29	467	13.3	872	10.7	1,848	9.9
30-49	2,217	63.1	5,833	71.6	13,623	72.9
50+	322	9.2	981	12.0	2,336	12.5
Unk	3	0.1	0	0.0	0	0.0
TOTAL	3,513	100.0	8,145	100.0	18,694	100.0
Race/Ethnicity						
White	732	20.8	1,580	19.4	4,580	24.5
Black	1,496	42.6	3,489	42.8	8,110	43.4
Hispanic	1,113	31.7	2,811	34.5	5,587	29.9
Asian/P1	88	2.5	215	2.6	355	1.9
Native Am	3	0.1	11	0.1	16	0.1
Multi Race	4	0.1	1	0.0	1	0.0
Other/Unk	77	2.2	38	0.5	45	0.2
TOTAL	3,513	100.0	8,145	100.0	18,694	100.0
Risk						
MSM	1,048	29.8	2,139	26.3	5,159	27.6
IDU	327	9.3	2,122	26.1	6,823	36.5
MSM/IDU	31	0.9	123	1.5	450	2.4
Heterosexual	737	21.0	1,359	16.7	2,238	12.0
Blood Prod.	19	0.5	63	0.8	186	1.0
Pediatric Risk	131	3.7	123	1.5	294	1.6
Other/Unk	1,220	34.7	2,216	27.2	3,544	19.0
TOTAL	3,513	100.0	8,145	100.0	18,694	100.0

*All cases reported and confirmed from June 2000 - June 2005
**All cases reported and confirmed from 1983 - June 2005

Table 22B

Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	226	65.9	408	67.2
Female	117	34.1	199	32.8
TOTAL	343	100.0	607	100.0
Age Group				
12 & under	1	0.3	0	0.0
13-19	14	4.1	7	1.2
20-24	27	7.9	32	5.3
25-29	47	13.7	53	8.7
30-49	214	62.4	402	66.2
50+	40	11.7	113	18.6
TOTAL	343	100.0	607	100.0
Race/Ethnicity				
White	67	19.5	82	13.5
Black	151	44.0	293	48.3
Hispanic	106	30.9	201	33.1
Asian/PI	14	4.1	29	4.8
Multi Race	2	0.6	0	0.0
Other/Unk	3	0.9	2	0.3
TOTAL	343	100.0	607	100.0
Risk				
MSM	115	33.5	151	24.9
IDU	24	7.0	70	11.5
MSM/IDU	2	0.6	9	1.5
Heterosexual	70	20.4	106	17.5
Blood Prod.	3	0.9	9	1.5
Other/Unk	129	37.6	262	43.2
TOTAL	343	100.0	607	100.0

*Cases reported and confirmed through June 2005

Table 23A

HIV/AIDS Cases by Gender, Age, Race/Ethnicity and Risk
Diagnosed through June 2004

	Living HIV*		Living AIDS**	
	Number	Percent	Number	Percent
Gender				
Male	321	56.2	661	65.3
Female	249	43.6	351	34.7
Unk	1	0.2	0	0.0
TOTAL	571	100.0	1,012	100.0
Age Group				
12 & under	33	5.8	15	1.5
13-19	12	2.1	11	1.1
20-24	38	6.7	26	2.6
25-29	49	8.6	82	8.1
30-49	380	66.5	761	75.2
50+	59	10.3	117	11.6
TOTAL	571	100.0	1,012	100.0
Race/Ethnicity				
White	177	31.0	387	38.2
Black	235	41.2	385	38.0
Hispanic	136	23.8	228	22.5
Asian/PI	8	1.4	4	0.4
Native Am	1	0.2	1	0.1
Multi Race	0	0.0	1	0.1
Other/Unk	14	2.5	6	0.6
TOTAL	571	100.0	1,012	100.0
Risk				
MSM	91	15.9	144	14.2
IDU	71	12.4	358	35.4
MSM/IDU	5	0.9	16	1.6
Heterosexual	89	15.6	175	17.3
Blood Prod.	4	0.7	11	1.1
Pediatric Risk	18	3.2	16	1.6
Other/Unk	293	51.3	292	28.9
TOTAL	571	100.0	1,012	100.0

*All cases reported and confirmed from June 2000 - June 2005

**All cases reported and confirmed from 1983 - June 2005

BOROUGH: STATEN ISLAND

Table 23B

Newly Diagnosed HIV/AIDS Cases* by Gender, Age, Race/Ethnicity and Risk
Diagnosed July 2003 - June 2004

	Initial HIV		Initial AIDS	
	Number	Percent	Number	Percent
Gender				
Male	23	50.0	38	62.3
Female	23	50.0	23	37.7
TOTAL	46	100.0	61	100.0
Age Group				
12 & under	0	0.0	1	1.6
13-19	5	10.9	1	1.6
20-24	5	10.9	1	1.6
25-29	1	2.2	3	4.9
30-49	27	58.7	42	68.9
50+	8	17.4	13	21.3
TOTAL	46	100.0	61	100.0
Race/Ethnicity				
White	9	19.6	20	32.8
Black	29	63.0	26	42.6
Hispanic	6	13.0	12	19.7
Asian/Pi	0	0.0	1	1.6
Native Am	1	2.2	0	0.0
Other/Unk	1	2.2	2	3.3
TOTAL	46	100.0	61	100.0
Risk				
MSM	9	19.6	7	11.5
IDU	2	4.3	14	23.0
Heterosexual	11	23.9	11	18.0
Blood Prod.	1	2.2	1	1.6
Other/Unk	23	50.0	28	45.9
TOTAL	46	100.0	61	100.0

*Cases reported and confirmed through June 2005

Graphic Display of NYS Descriptive Data

For those who prefer graphic presentations, the Bureau of HIV/AIDS Epidemiology has displayed the basic descriptors of New York State by geographic area and Ryan White Region.

These areas include:

New York State

New York City

The Boroughs of New York City:

- The Bronx
- Brooklyn
- Manhattan
- Queens
- Staten Island

Upstate New York

(New York State *excluding* New York City)

The Ryan White Regions of Upstate NY

- Albany
- Binghamton
- Buffalo
- Lower Hudson
- Mid Hudson
- Nassau/Suffolk
- Rochester
- Syracuse

Epidemiologic Profile of New York State^{1/}

Figure 1 Persons Living with HIV and AIDS and Cumulative AIDS Cases*

Region of Residence at Time of Diagnosis	Living with HIV Infection	Living with AIDS	Cumulative AIDS Cases
Albany Region	1,538	1,907	3,951
Binghamton Region	150	179	356
Bronx	7,120	11,885	28,102
Brooklyn	7,203	14,398	35,767
Buffalo Region	1,259	1,527	3,173
Lower Hudson Region	1,283	2,759	6,082
Manhattan	10,084	17,668	47,357
Mid Hudson Region	1,139	1,962	4,389
Nassau/Suffolk Region	1,473	3,058	7,584
Queens	3,643	8,210	18,712
Rochester Region	1,035	1,379	2,891
Staten Island	579	1,026	2,744
Syracuse Region	1,251	1,647	3,205
Total	37,757	67,605	164,313

*Only regions outside of NYC include cases identified as prisoners since the majority of prisoners are diagnosed in state correctional facilities which are located outside NYC.

Childbearing Women:

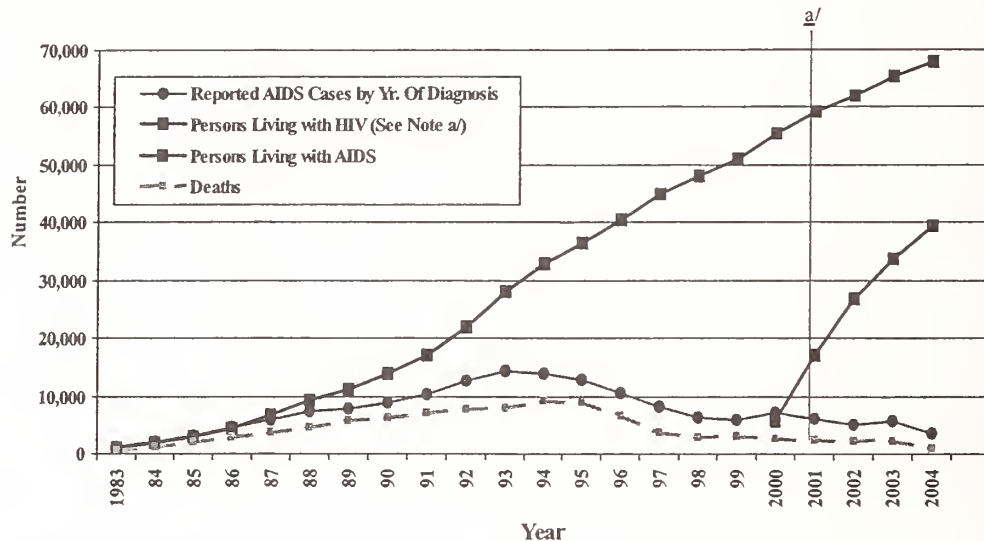
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in New York State had a prevalence of 0.30% (n=727), or approximately 1 in 333 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York State^{1/}

Figure 2

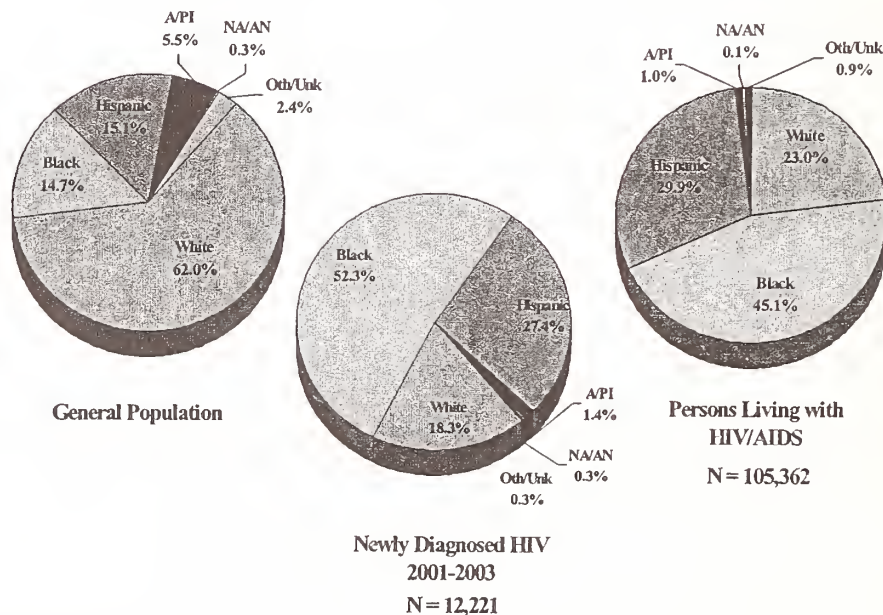
Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} in New York State - 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Includes prisoners for regions outside of NYC.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York State^{1/}

Figure 4

New York State Males* Living with HIV/AIDS by Race/Ethnicity and Transmission Category

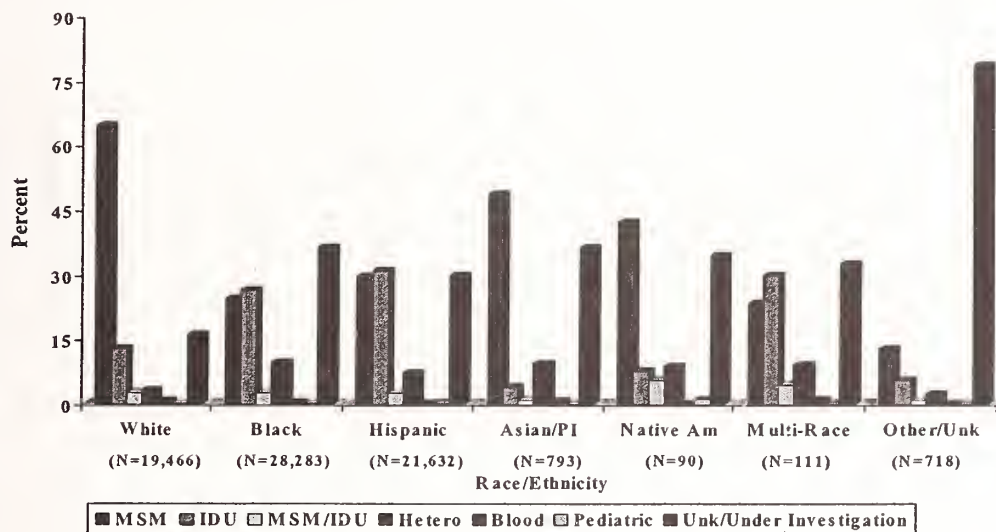
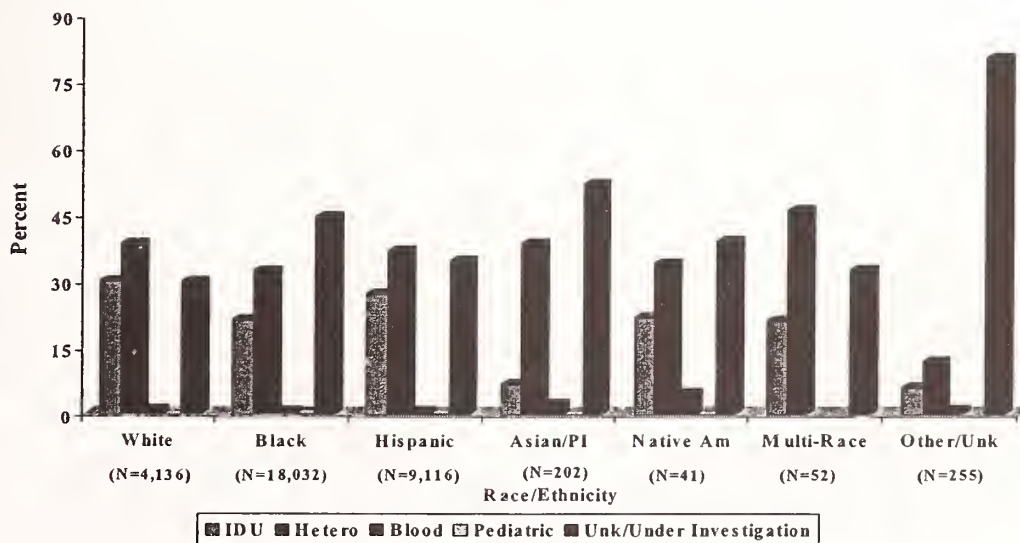


Figure 5

New York State Females* Living with HIV/AIDS by Race/Ethnicity and Transmission Category



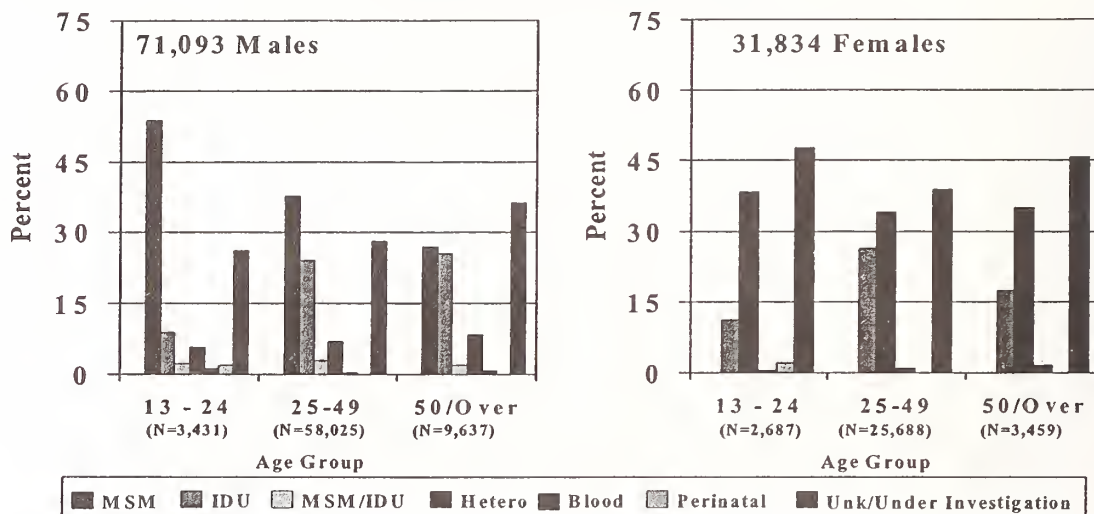
* Includes prisoners for regions outside of NYC.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York State^{1/}

Figure 6

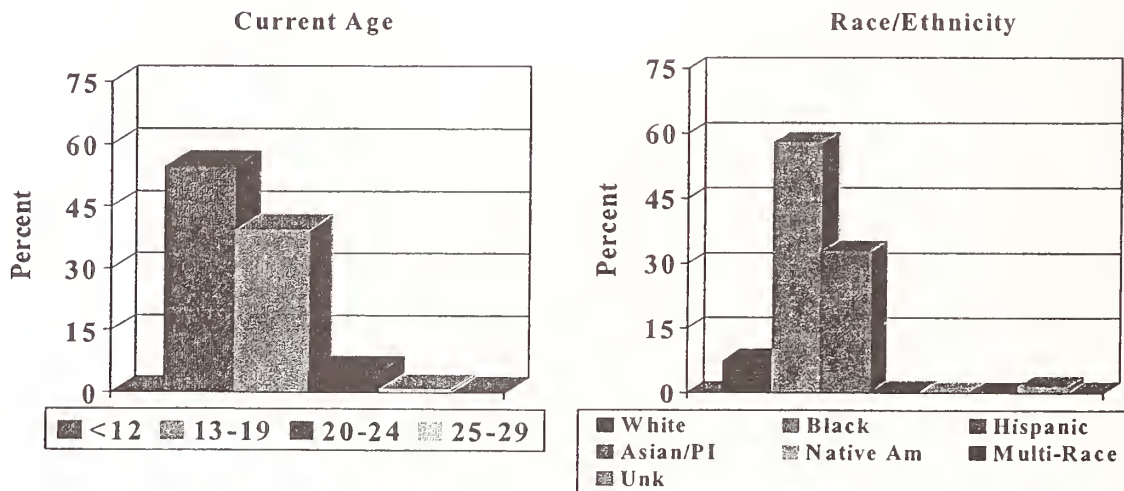
Persons* Living in New York State with HIV and AIDS by Gender, Transmission Category and Age Group



* Includes prisoners for regions outside NYC; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons Living in New York State With Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 2,364)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York City¹

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases*

County of Residence At Time of Diagnosis	Living with HIV Infection	Living with AIDS	Cumulative AIDS Cases
Bronx	7,120	11,885	28,102
Brooklyn	7,203	14,398	35,767
Manhattan	10,084	17,668	47,357
Queens	3,643	8,210	18,712
Staten Island	579	1,026	2,744
TOTAL	28,629	53,187	132,682

*Excludes prisoners.

Childbearing Women:

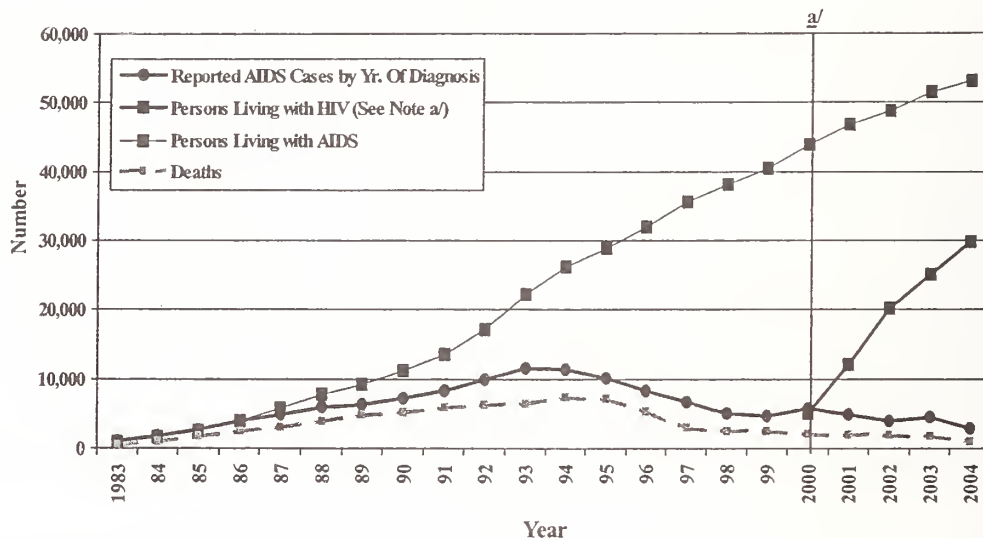
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in New York City had a prevalence of 0.51% (n=578), or approximately 1 in 196 women giving birth had a positive HIV test result.

¹/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York City^{1/}

Figure 2

Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*

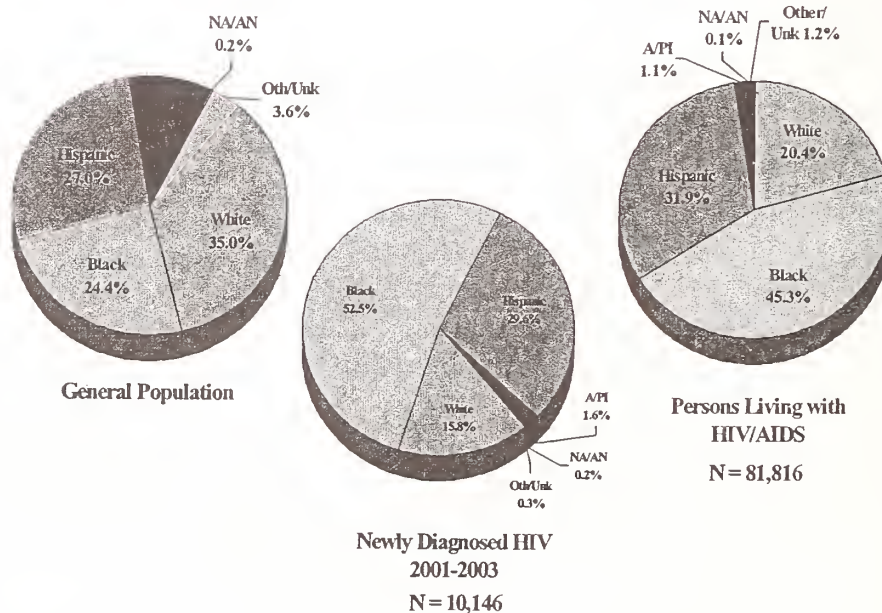


a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.

b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Excludes prisoners.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York City^{1/}

Figure 4

New York City Males* Living with HIV/AIDS by Race/Ethnicity and Transmission Category

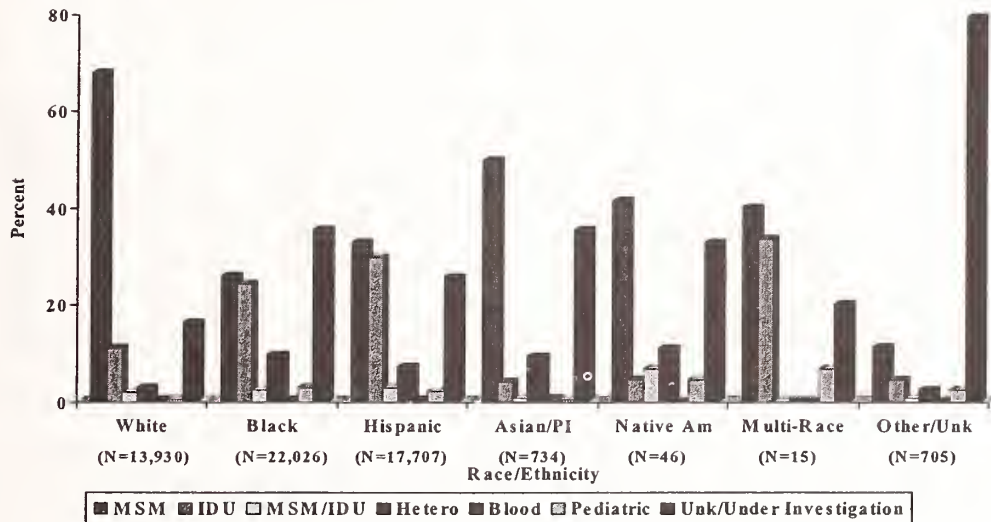
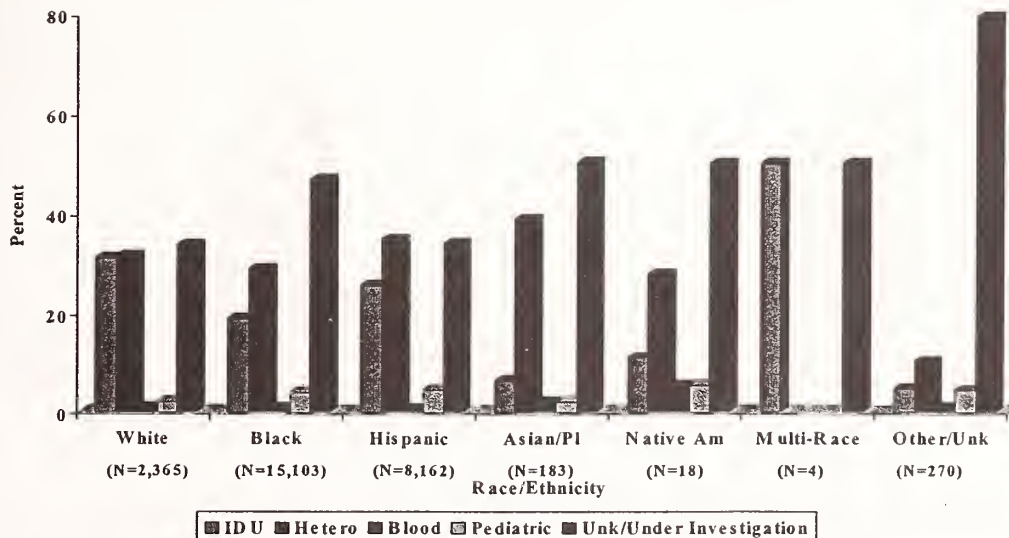


Figure 5

New York City Females* Living with HIV/AIDS by Race/Ethnicity and Transmission Category



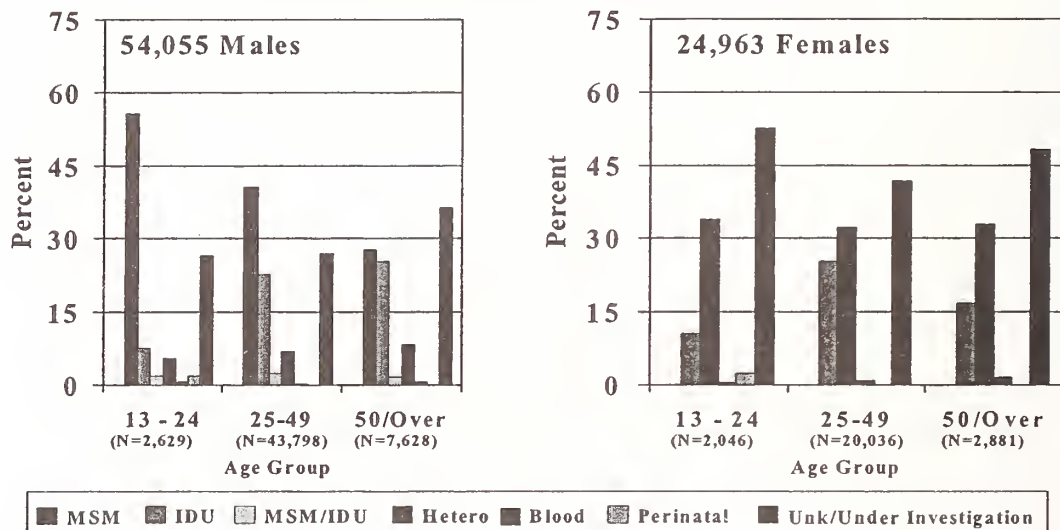
* Excludes Prisoners

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York City^{1/}

Figure 6

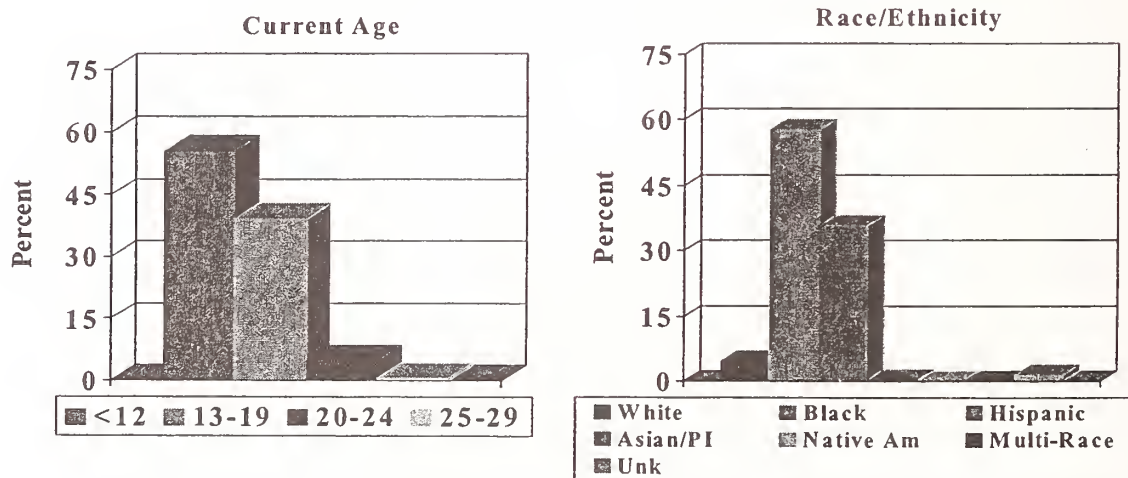
Persons* Living in New York City, with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons Living in New York City With Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 2,063)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Bronx, New York City^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases*

United Hospital Fund Neighborhood at Time of Diagnosis	Living with HIV Infection	Living with AIDS	Cumulative AIDS Cases
Kingsbridge-Riverdale	156	298	692
Northeast Bronx	519	823	1,818
Fordham-Bronx Park	1,251	2,090	4,706
Pelham-Throgs Neck	1,056	1,801	4,235
Crotona-Tremont	1,419	2,375	5,663
High Bridge-Morisania	1,437	2,557	6,138
Hunts Point – Mott Haven	922	1,614	3,930
Unknown	360	327	920
TOTAL	7,120	11,885	28,102

*Excludes prisoners.

Childbearing Women:

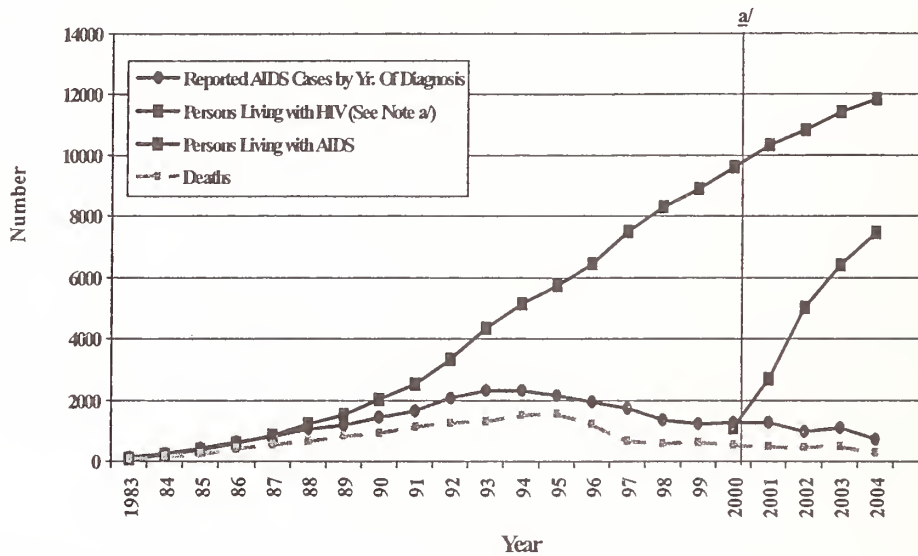
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in the Bronx had a prevalence of 0.95% (n=206), or approximately 1 in 105 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Bronx, New York City^{1/}

Figure 2

Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*

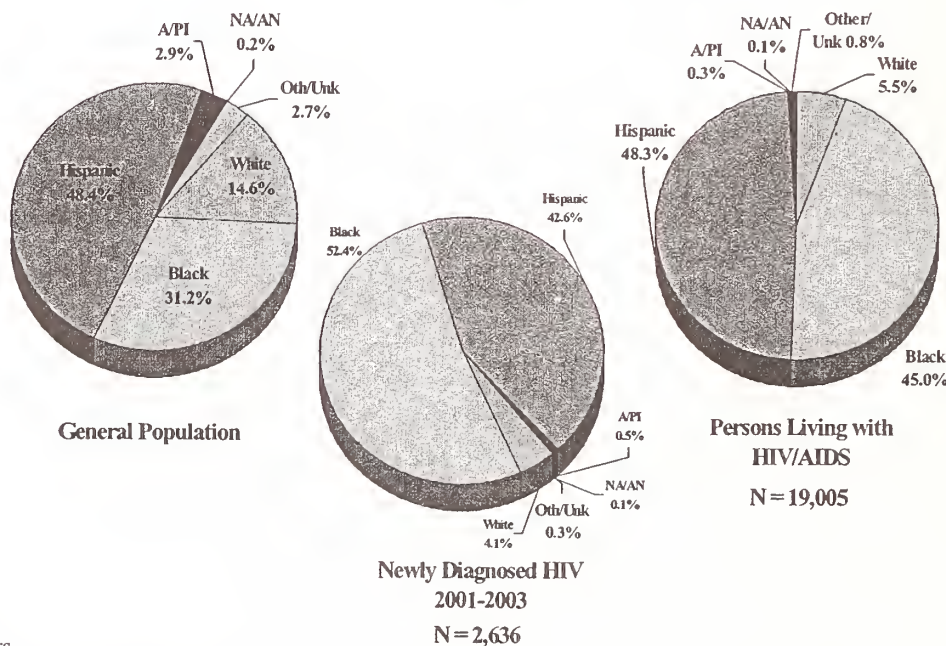


^{a/} HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.

^{b/} Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Excludes prisoners.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Bronx, New York City^{1/}

Figure 4

Males* Living with HIV/AIDS by Race/Ethnicity and Transmission Category

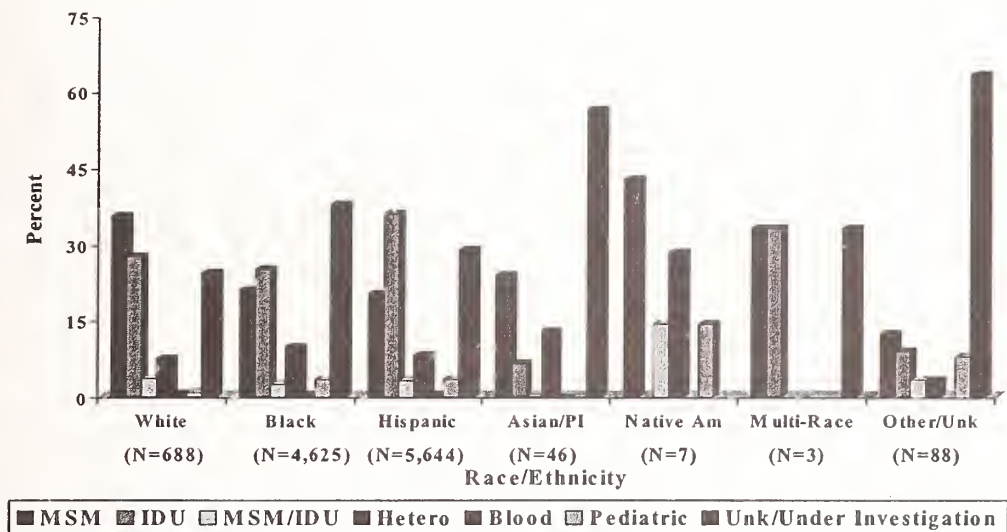
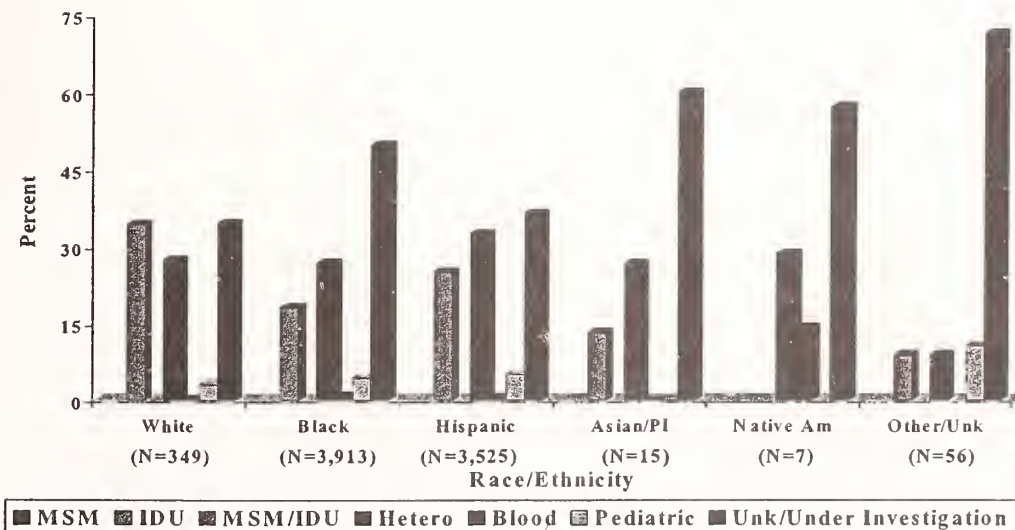


Figure 5

Females* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category



* Excludes Prisoners

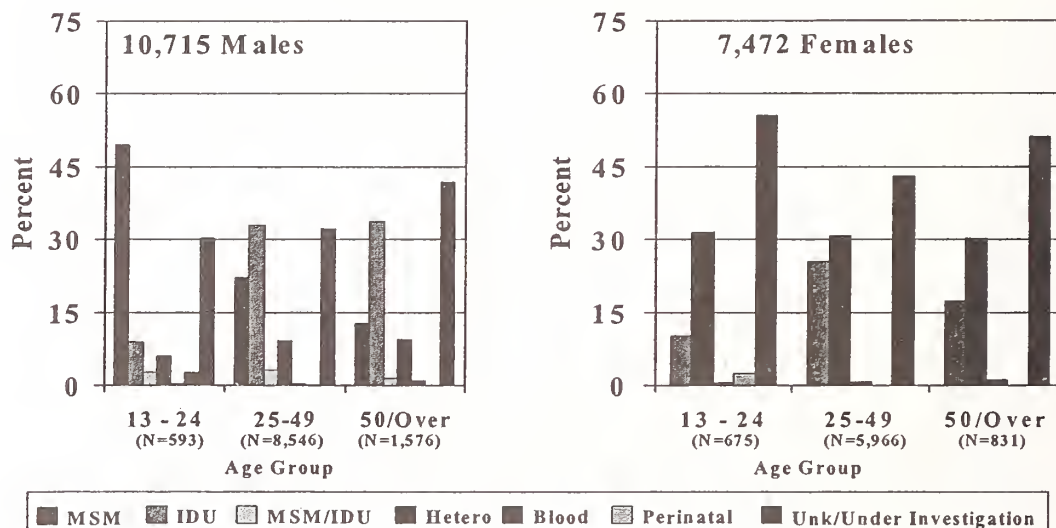
** There were no Multi-Race cases.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Bronx, New York City^{1/}

Figure 6

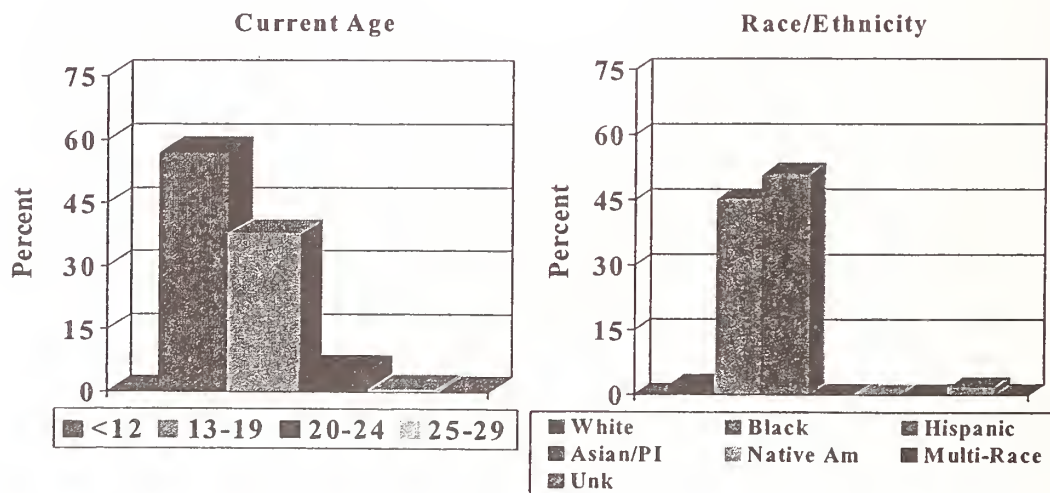
Persons* Living with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons Living With Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 726)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Brooklyn, New York City^{1/}

Figure 1 **Persons Living with HIV and AIDS and Cumulative AIDS Cases***

United Hospital Fund Neighborhood at Time of Diagnosis	Living with HIV Infection	Living with AIDS	Cumulative AIDS Cases
Greenpoint	243	556	1,461
Downtown-Heights-Slope	814	1,697	4,755
Bedford Styvesant-Crown Heights	1,704	3,472	8,624
East New York	728	1,402	3,218
Sunset Park	178	448	1,123
Borough Park	243	548	1,461
East Flatbush-Flatbush	1,027	2,315	4,993
Canarsie-Flatlands	353	561	1,161
Bensonhurst-Bay Ridge	144	288	856
Coney Island-Sheepshead Bay	267	661	1,703
Williamsburg-Bushwick	874	1,956	4,970
Unknown	628	494	1,442
Totals	7,203	14,398	35,767

*Excludes prisoners.

Childbearing Women:

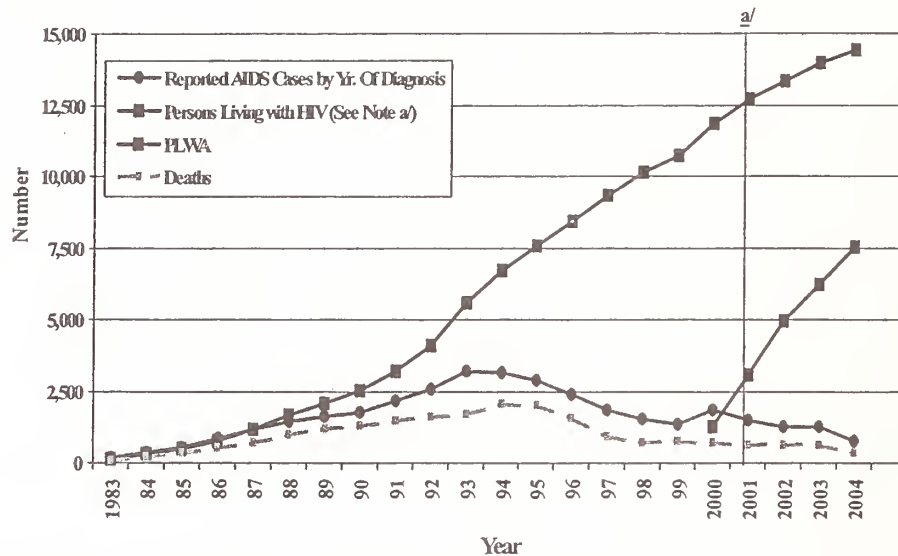
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in Brooklyn had a prevalence of 0.54% (n=205), or approximately 1 in 185 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Brooklyn, New York City¹

Figure 2

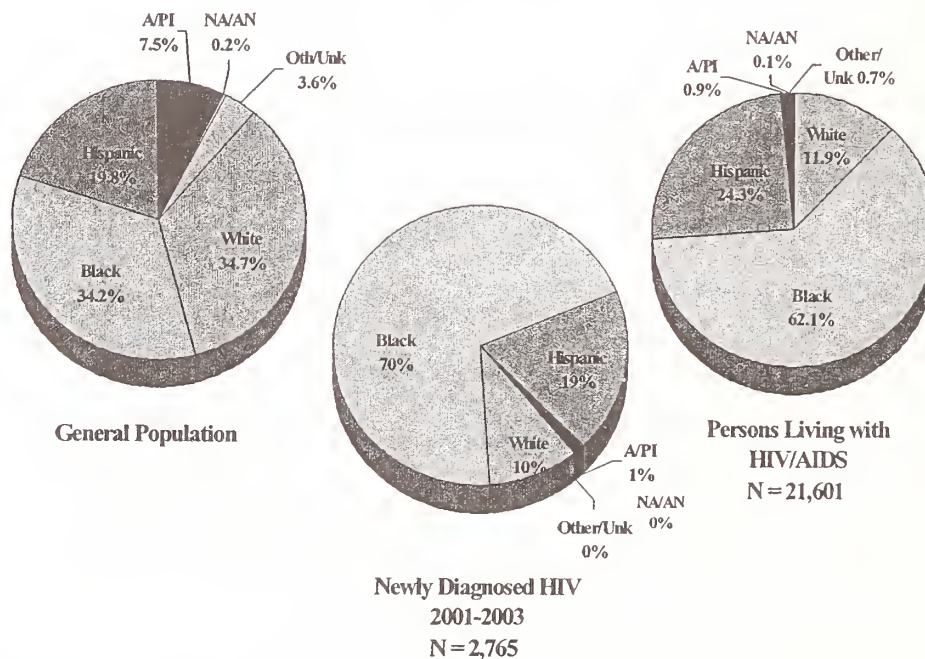
Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^b 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



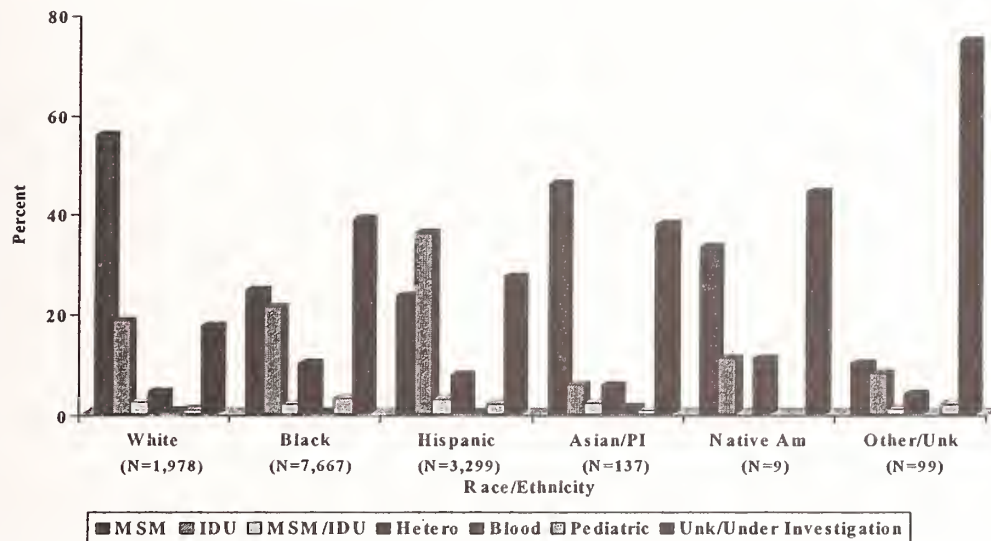
* Excludes prisoners.

1/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Brooklyn, New York City ^{1/}

Figure 4

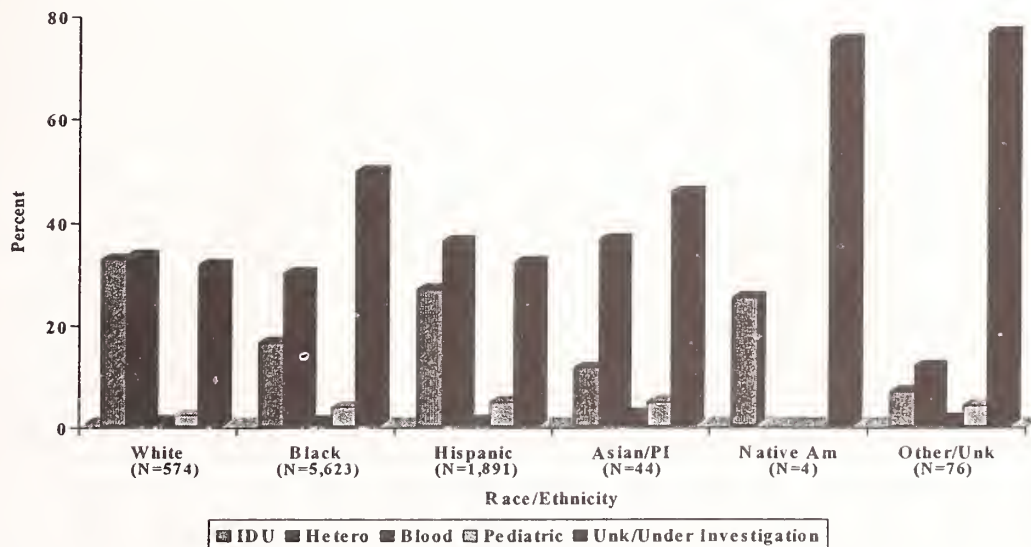
Males* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category



**Multi-Race data not included due to small cell size.

Figure 5

Females* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category



* Excludes Prisoners

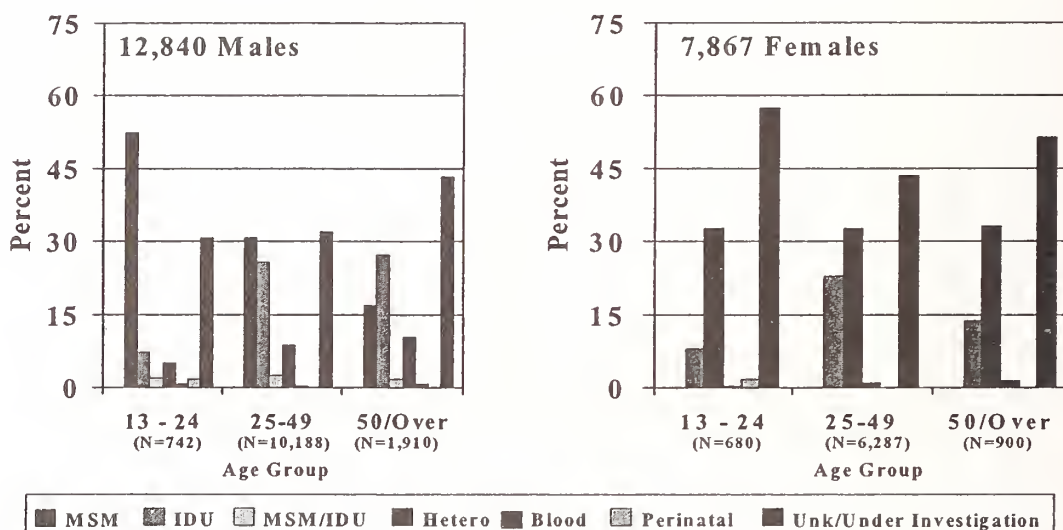
** There were no Multi-Race cases.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Brooklyn, New York City ^{1/}

Figure 6

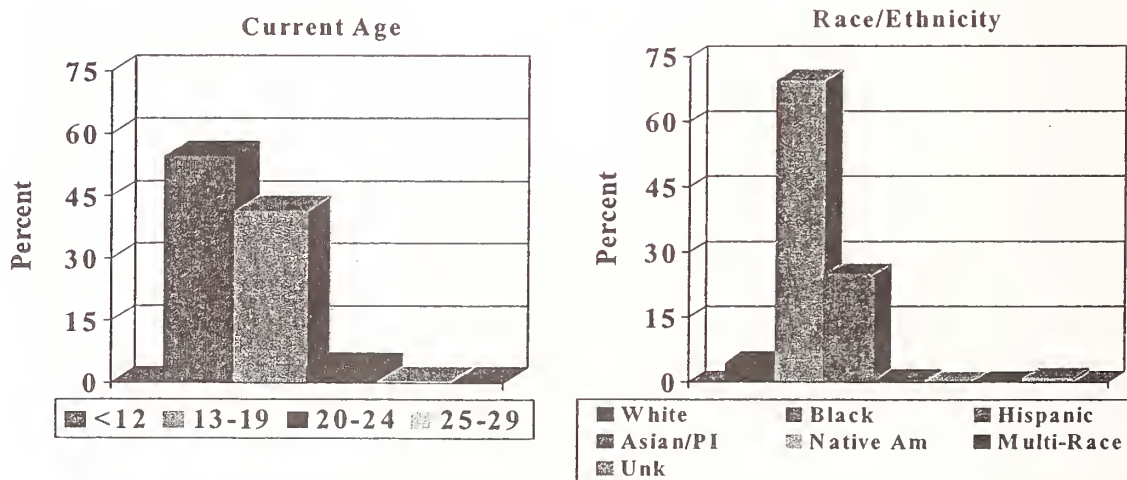
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons with Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 617)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Manhattan, New York City¹

Figure 1 **Persons Living with HIV and AIDS and Cumulative AIDS Cases***

United Hospital Fund Neighborhood at Time of Diagnosis	Living with HIV Infection	Living with AIDS	Cumulative AIDS Cases
Washington Heights – Inwood	1,069	1,970	4,469
Central Harlem-Morningside Heights	1,276	2,286	6,064
East Harlem	880	1,631	4,436
Upper West Side	917	1,989	6,221
Upper East Side	400	822	2,209
Chelsea-Clinton	1,885	2,939	7,472
Gramercy Park-Murray Hill	604	1,250	3,383
Greenwich Village-Soho	608	1,181	3,477
Union Square-Lower East Side	951	1,907	5,547
Lower Manhattan	131	209	513
Unknown	1,363	1,484	3,566
TOTAL	10,084	17,668	47,357

*Excludes prisoners.

Childbearing Women:

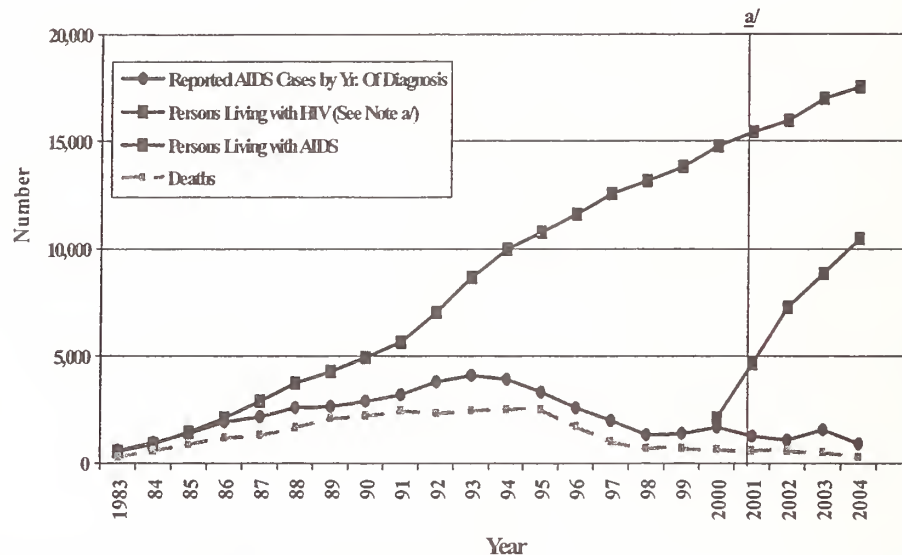
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in Manhattan had a prevalence of 0.47% (n=91), or approximately 1 in 213 women giving birth had a positive HIV test result.

¹/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Manhattan, New York City^{1/}

Figure 2

Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*

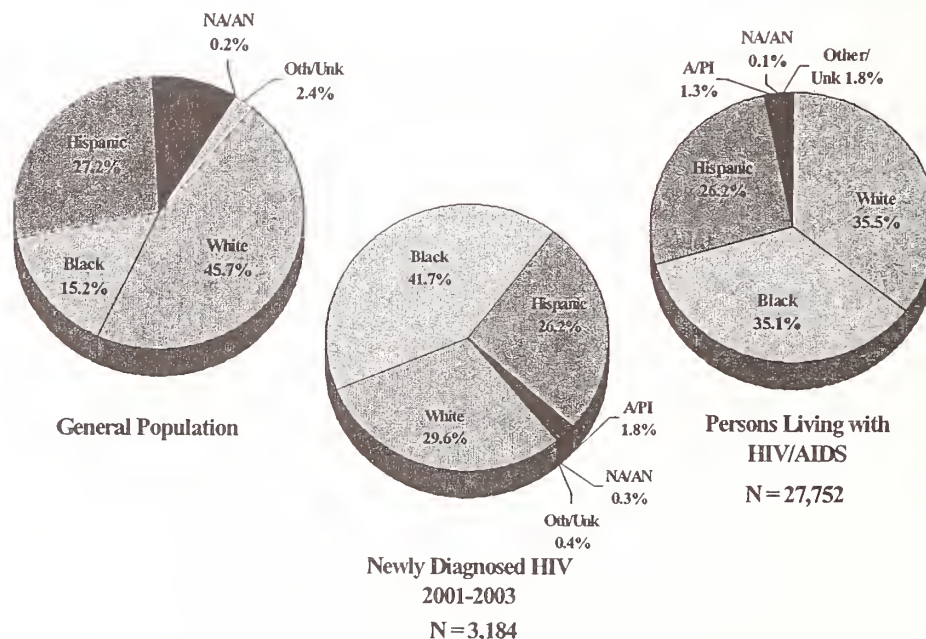


a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.

b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Excludes prisoners.

1/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Manhattan, New York City^{1/}

Figure 4

Males* Living with HIV/AIDS by Race/Ethnicity and Transmission Category

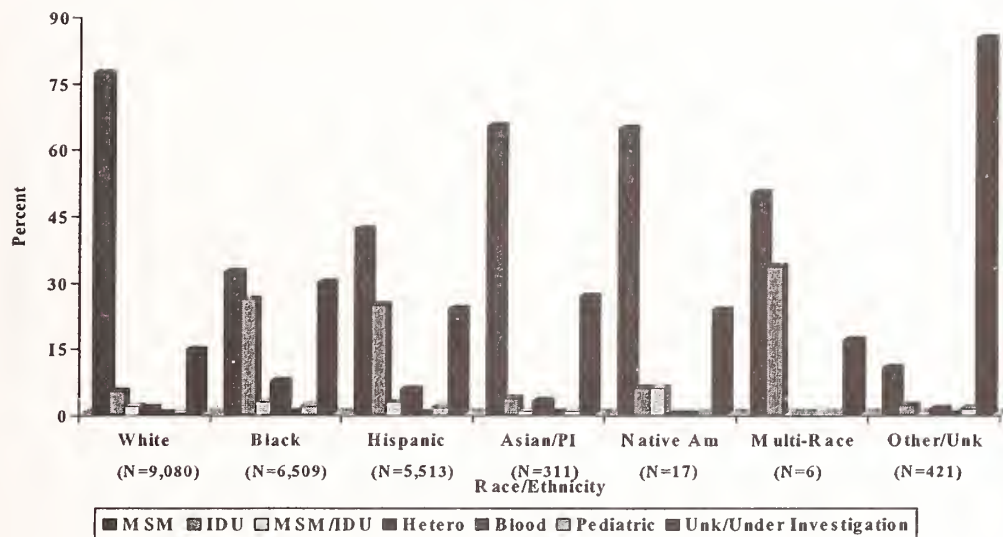
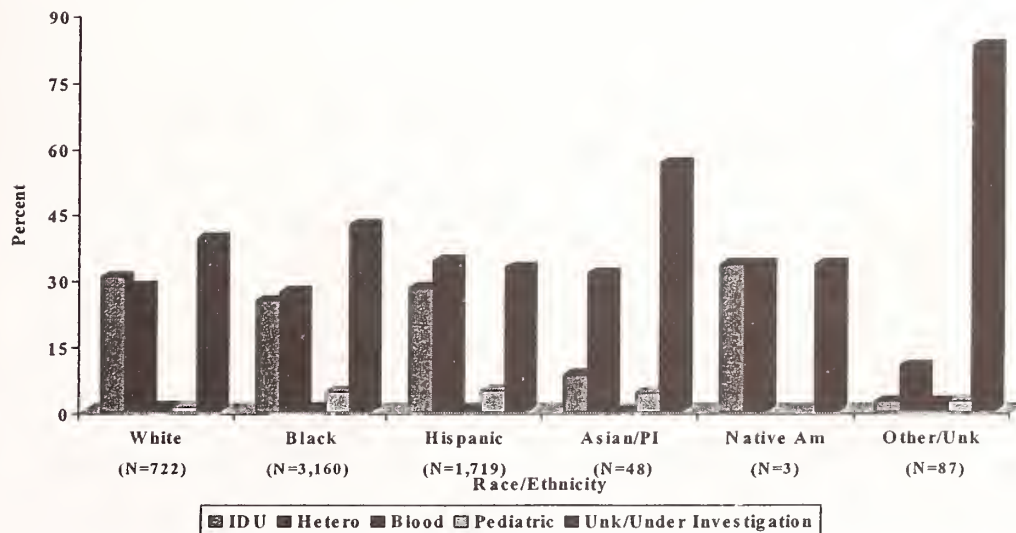


Figure 5

Females* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category



* Excludes Prisoners

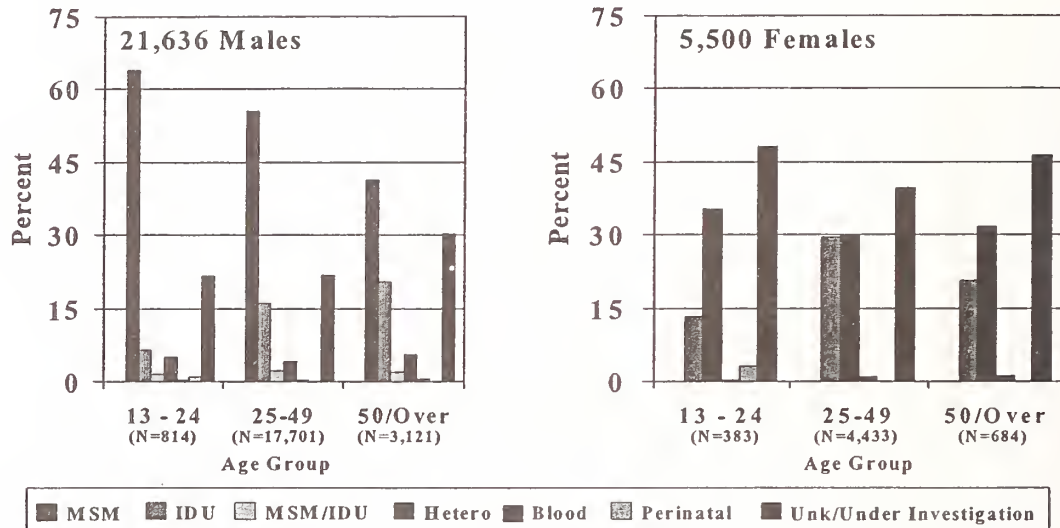
** Multi-Race data not included due to small cell size.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Manhattan, New York City^{1/}

Figure 6

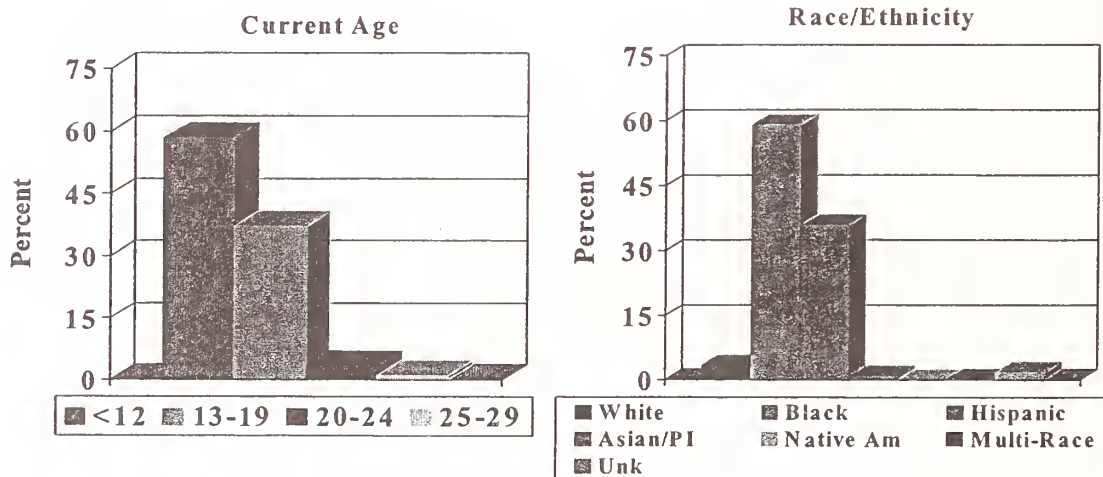
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons with Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 432)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Queens, New York City¹

Figure 1 **Persons Living with HIV and AIDS and Cumulative AIDS Cases***

United Hospital Fund Neighborhood at Time of Diagnosis	Living with HIV Infection	Living with AIDS	Cumulative AIDS Cases
Long Island City-Astoria	499	876	1,940
West Queens	798	2,400	4,977
Flushing-Clearview	171	413	948
Bayside – Little Neck	35	88	225
Ridgewood-Forest Hills	283	529	1,248
Fresh Meadows	72	128	326
Southwest Queens	357	719	1,760
Jamaica	710	1,535	3,741
Southeast Queens	280	617	1,333
Rockaway	244	442	1,085
Unknown	194	463	1,129
TOTAL	3,643	8,210	18,712

*Excludes prisoners.

Childbearing Women:

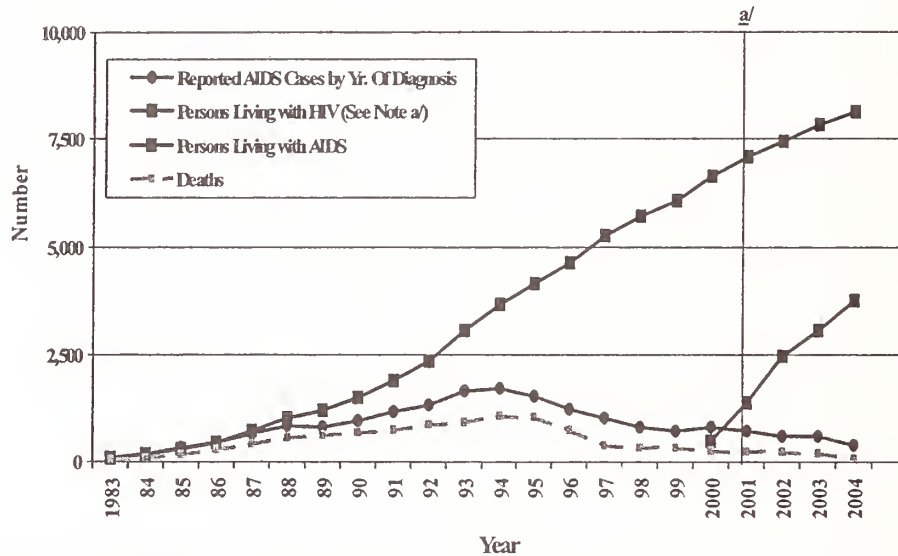
2002 data of the NYS Comprehensive Newborn Screening Program notes that women giving birth in Queens had a prevalence of 0.21% (n=63), or approximately 1 in 476 women giving birth had a positive HIV test result.

1/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Queens, New York City^{1/}

Figure 2

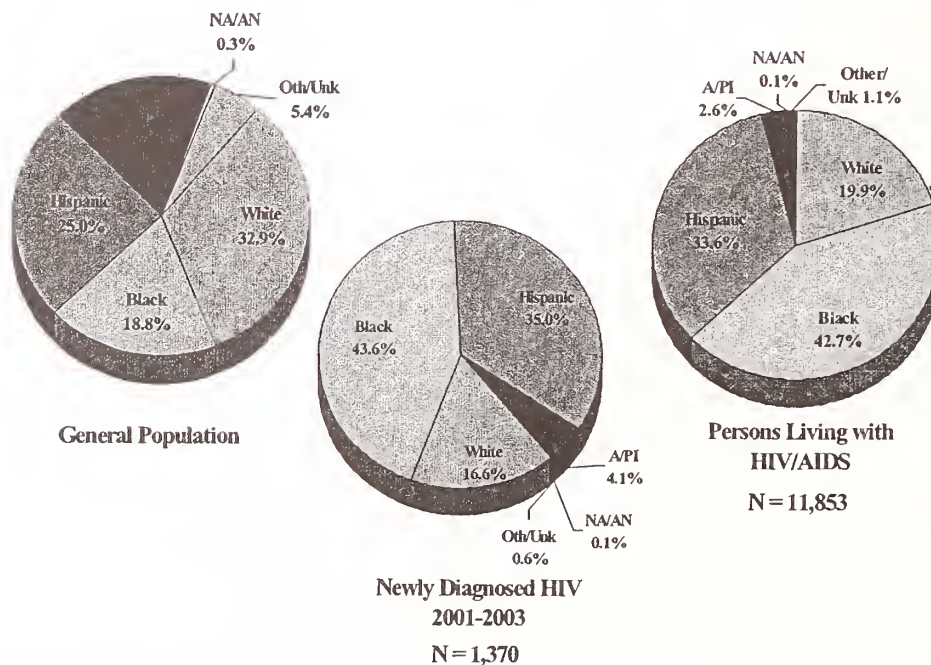
Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Excludes prisoners.

1/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Queens, New York City^{1/}

Figure 4

Males* Living with HIV/AIDS by Race/Ethnicity and Transmission Category

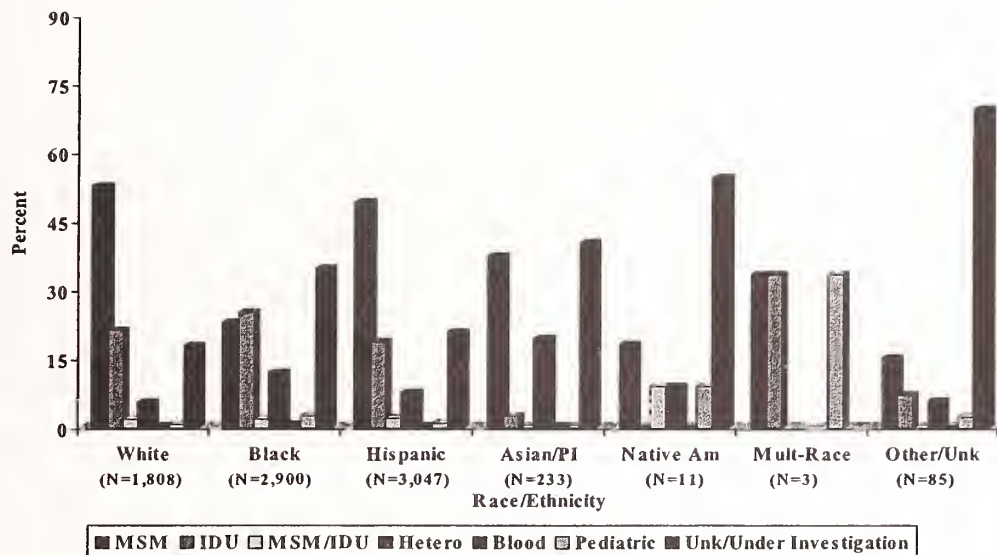
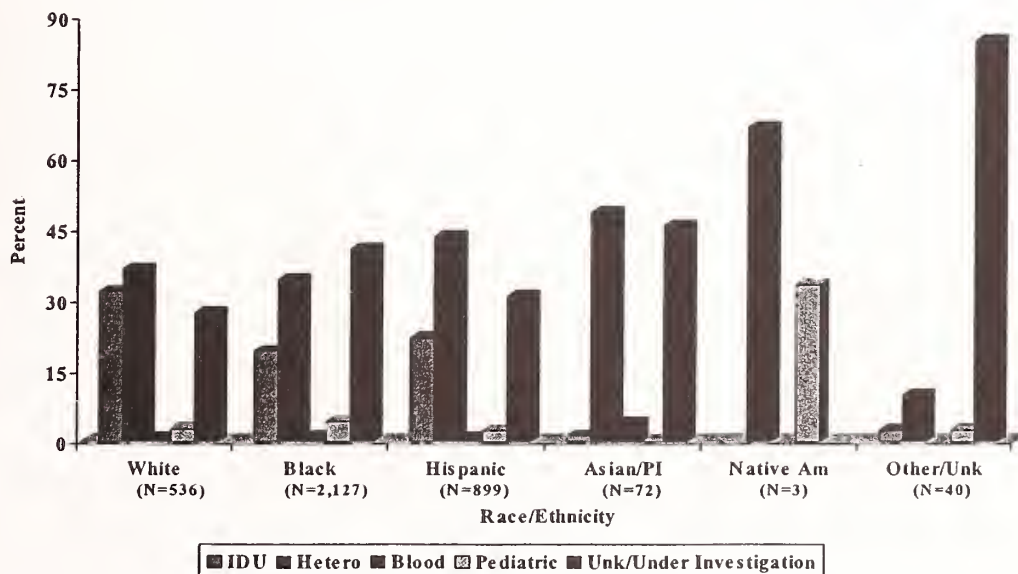


Figure 5

Females* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category



* Excludes Prisoners

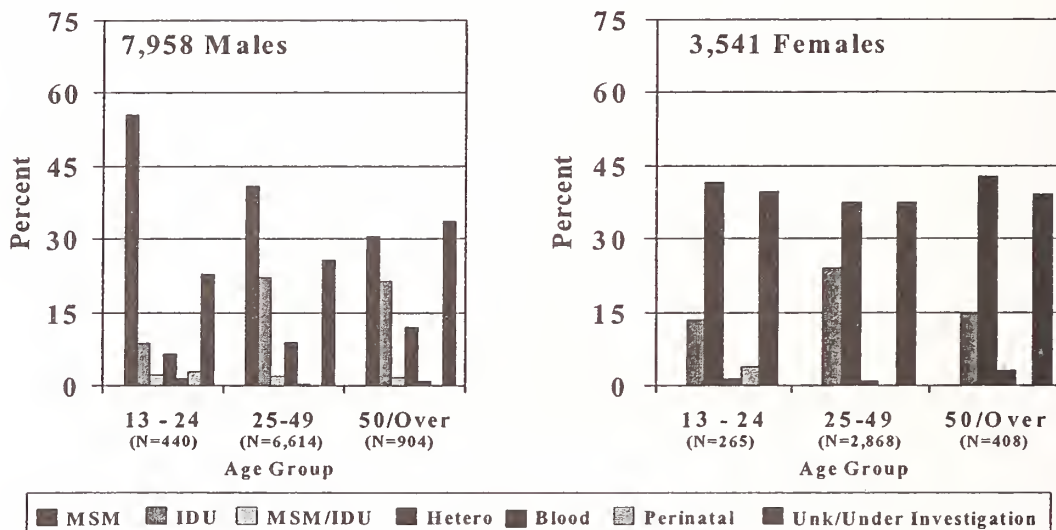
** Multi-Race data not included due to small cell size.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Queens, New York City¹

Figure 6

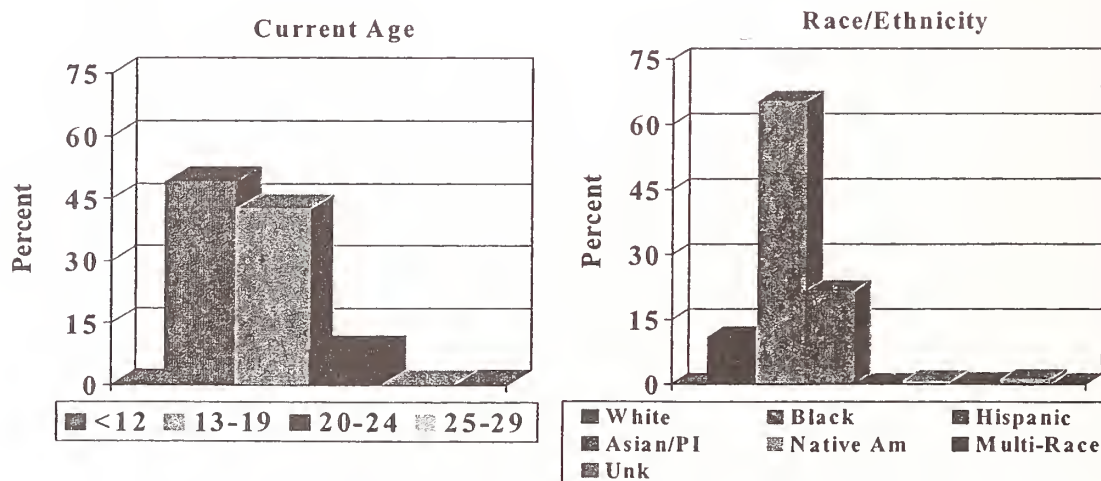
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons with Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 255)



¹/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Staten Island, New York City^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases*

United Hospital Fund Neighborhood at Time of Diagnosis	Living with HIV Infection	Living with AIDS	Cumulative AIDS Cases
Port Richmond	111	207	525
Stapleton-St. George	247	459	1,241
Willowbrook	42	73	240
South Beach-Tottenville	110	193	580
Unknown	69	94	158
TOTAL	579	1,026	2,744

*Excludes prisoners.

Childbearing Women:

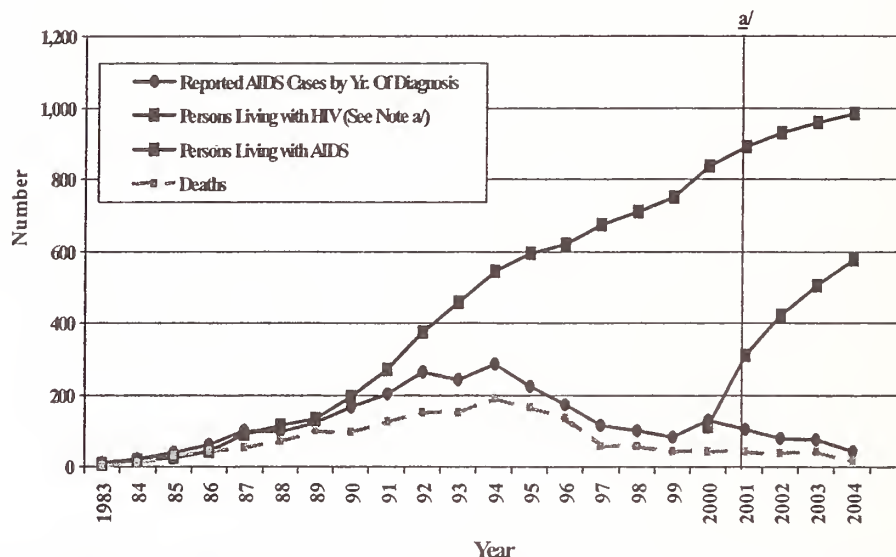
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in Staten Island had a prevalence of 0.24% (n=13), or approximately 1 in 417 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Staten Island, New York City^{1/}

Figure 2

Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*

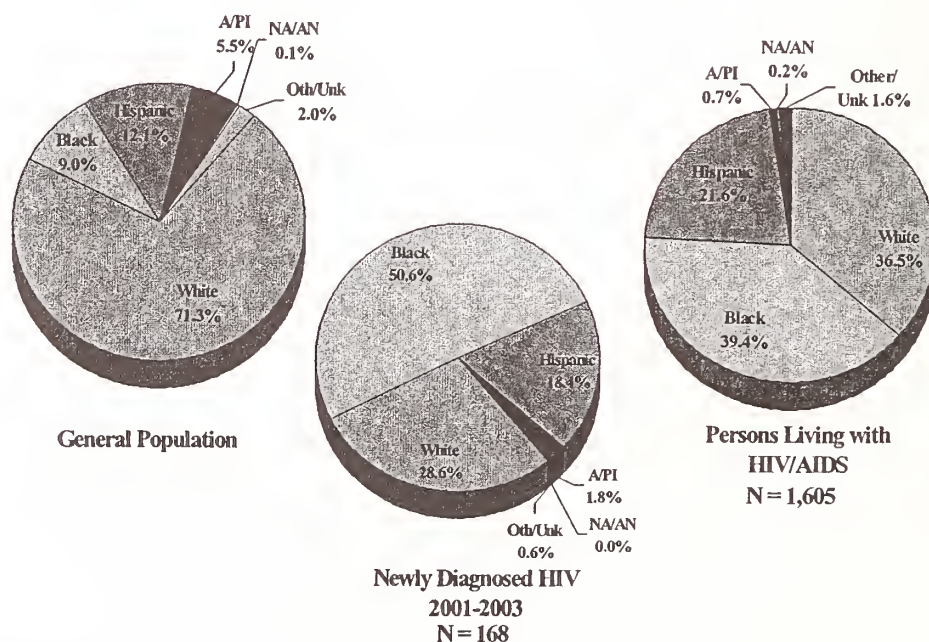


a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.

b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



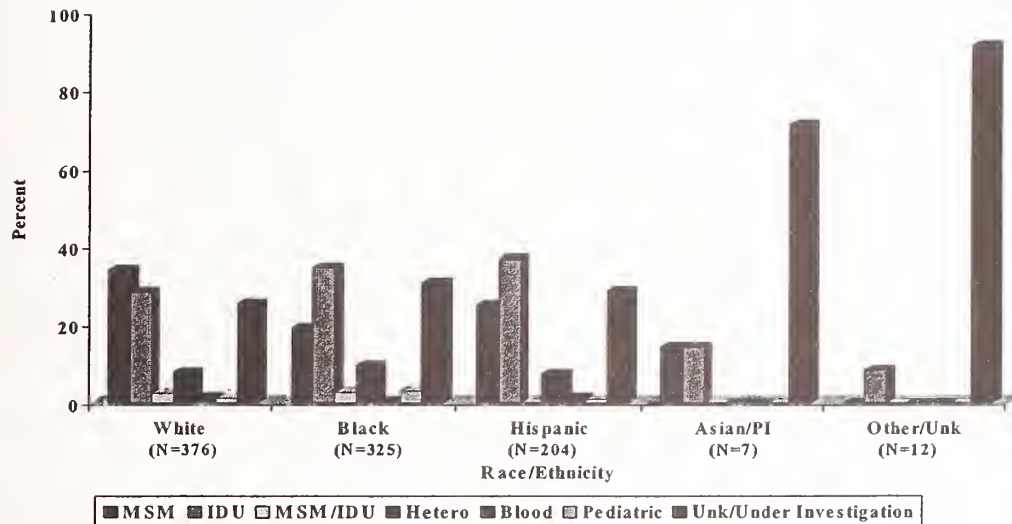
* Excludes prisoners.

1/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Staten Island, New York City^{1/}

Figure 4

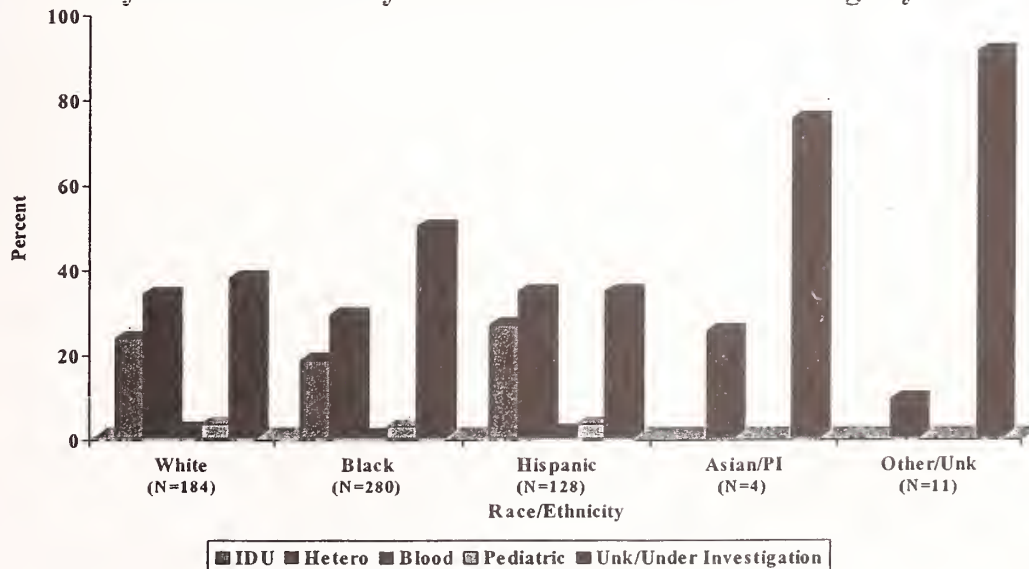
**Males* Living with HIV/AIDS
by Race/Ethnicity** and Transmission Category**



**Native American and Multi-Race data not included due to small cell sizes

Figure 5

**Females* Living with HIV/AIDS
by Race/Ethnicity** and Transmission Category**



* Excludes Prisoners

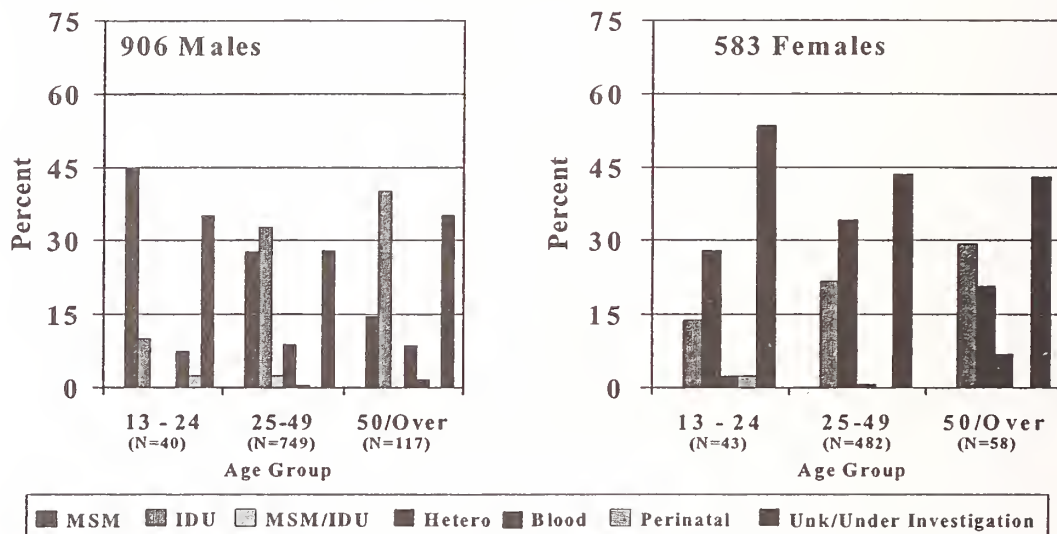
** Native American data not included due to small cell sizes. There were no Multi-Race cases.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Staten Island, New York City^{1/}

Figure 6

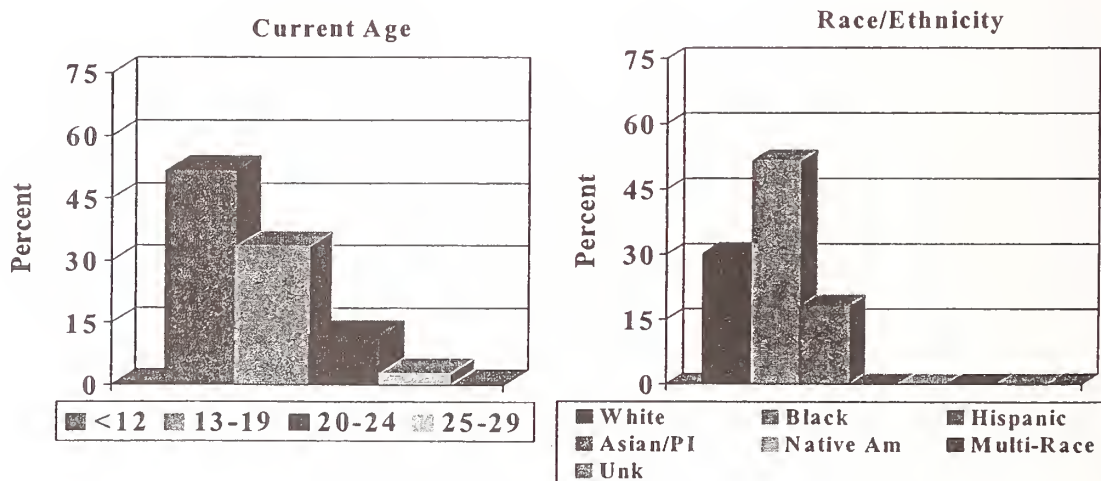
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons with Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 33)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York State, Excluding New York City^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases

Region of Residence at Time of Diagnosis	Living with HIV Infection		Living with AIDS		Cumulative AIDS Cases	
	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners
Albany	861	1,538	1,161	1,907	2,497	3,951
Binghamton	142	150	166	179	337	356
Buffalo	714	1,259	1,021	1,527	2,310	3,173
Lower Hudson	1,009	1,283	2,419	2,759	5,529	6,082
Mid-Hudson	685	1,139	1,298	1,962	3,064	4,389
Nassau/Suffolk	1,431	1,473	3,005	3,058	7,477	7,584
Rochester	747	1,035	1,162	1,379	2,512	2,891
Syracuse	562	1,251	915	1,647	1,936	3,205
Totals	6,151	9,128	11,147	14,418	25,662	31,631

Childbearing Women:

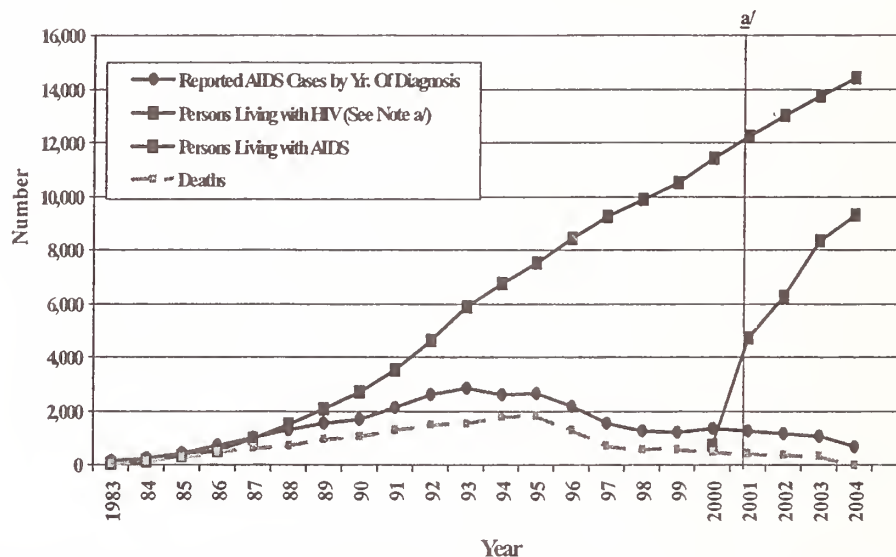
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in New York State, excluding NYC, had a prevalence of 0.12% (n=144), or approximately 1 in 833 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York State, Excluding New York City^{1/}

Figure 2

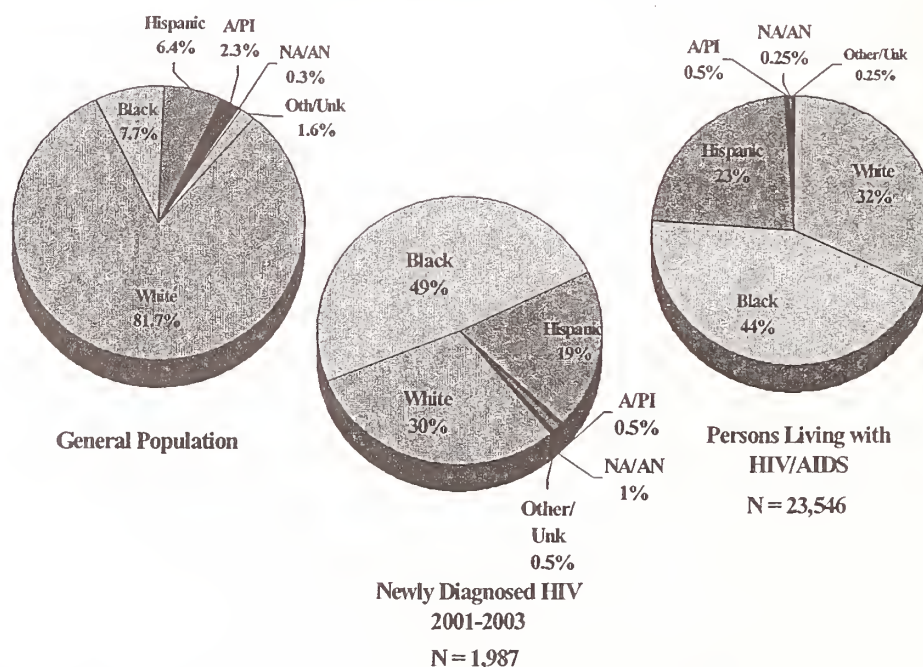
Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Includes prisoners

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York State, Excluding New York City^{1/}

Figure 4

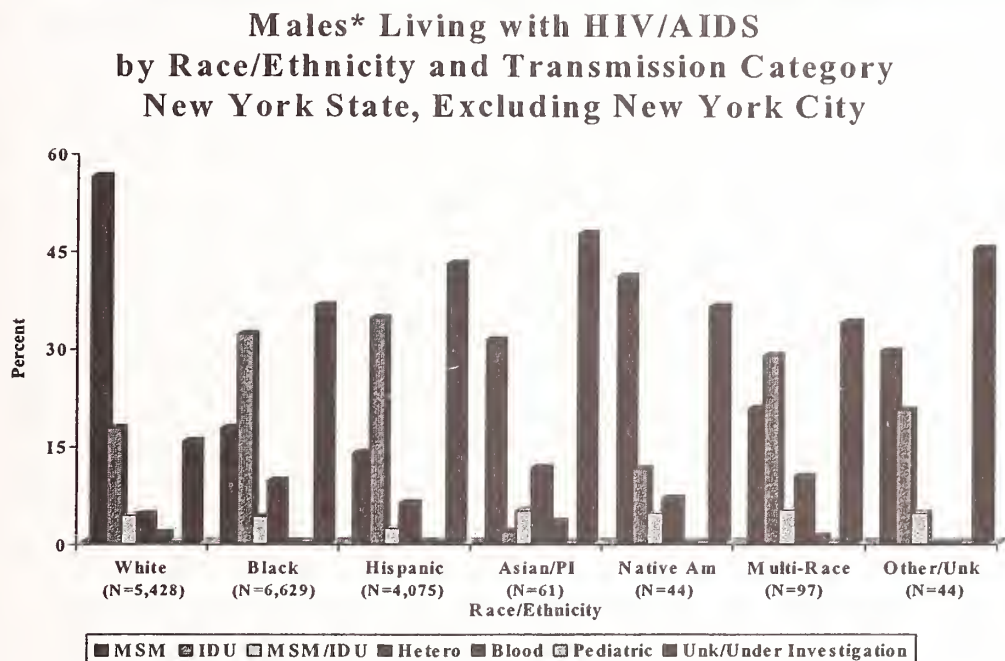
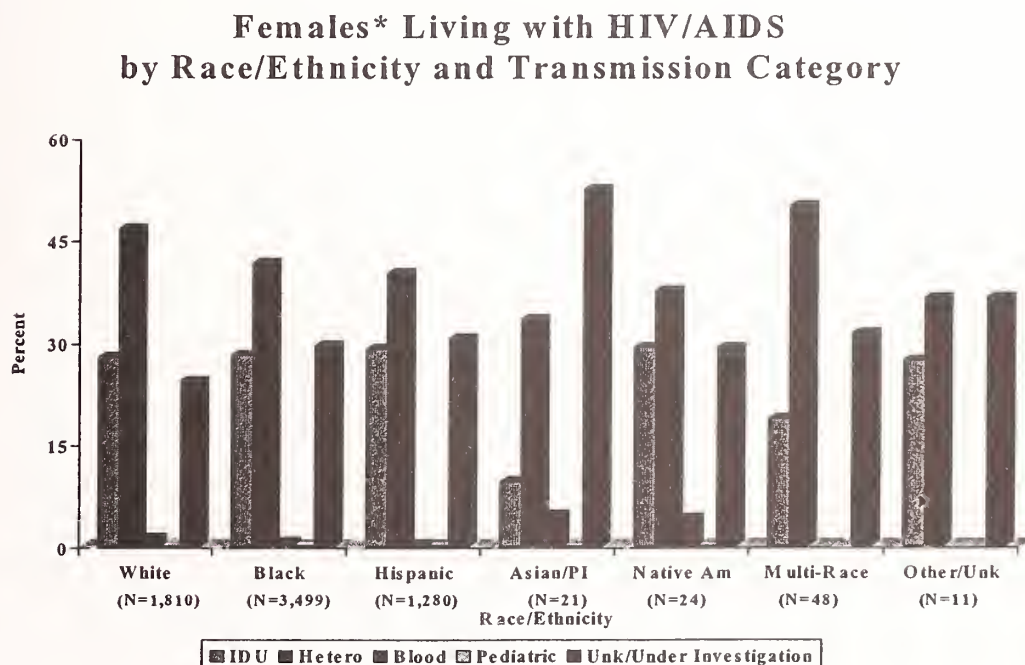


Figure 5



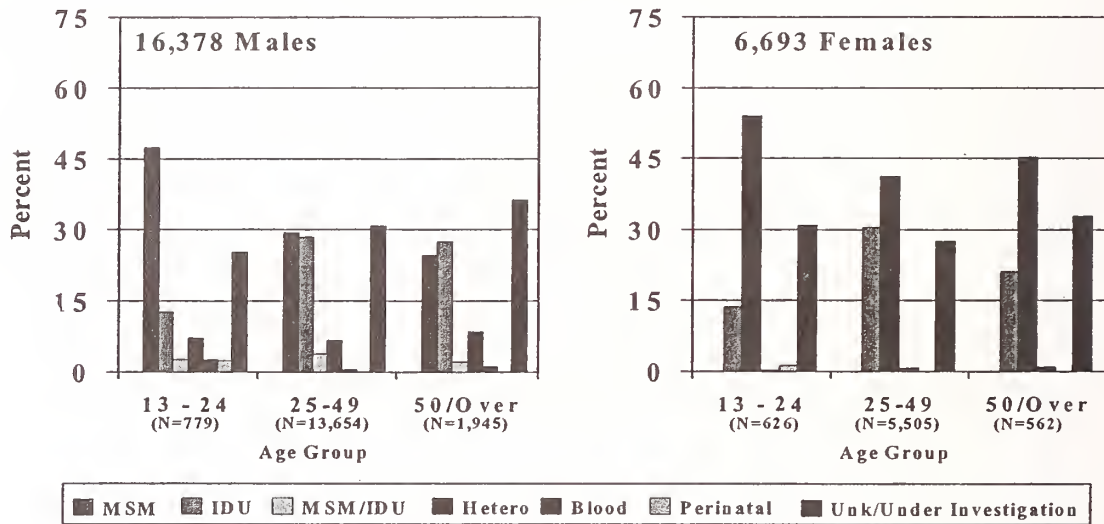
* Includes Prisoners.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of New York State, Excluding New York City^{1/}

Figure 6

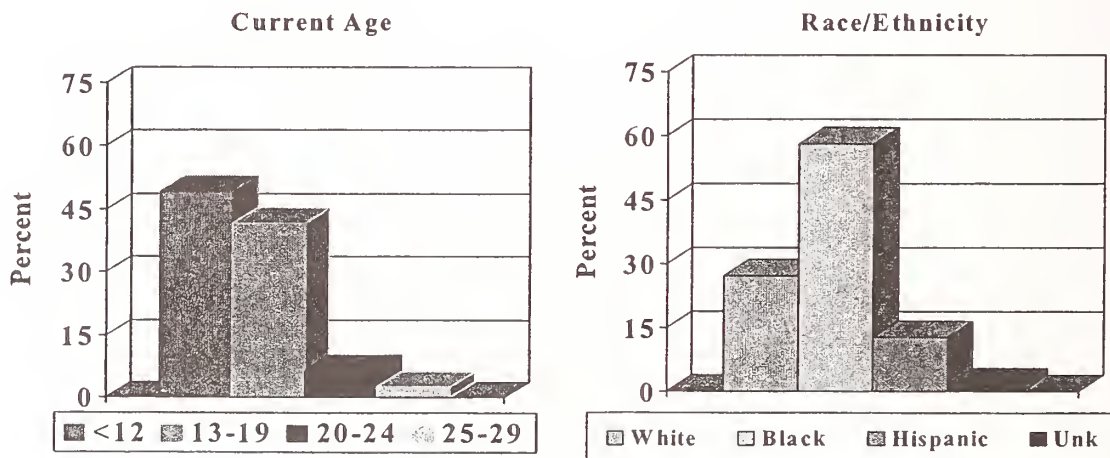
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Includes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons with Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 301) New York State, Excluding New York City



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Albany (Northeast) Ryan White Region^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases

County of Residence at Time of Diagnosis	Living with HIV Infection		Living with AIDS		Cumulative AIDS Cases	
	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners
Albany	348	383	496	516	1,040	1,070
Clinton	19	133	27	210	58	445
Columbia	30	73	30	57	79	130
Delaware	21	21	21	22	41	42
Essex	11	56	16	82	48	180
Franklin	13	235	20	223	36	366
Fulton	18	21	20	21	40	42
Greene	22	76	39	116	69	209
Hamilton	1	1	1	1	2	2
Montgomery	27	29	29	29	71	71
Otsego	21	21	31	32	66	67
Rensselaer	87	91	124	128	253	257
Saratoga	42	87	77	132	175	291
Schenectady	156	163	172	184	380	393
Schoharie	13	20	8	12	33	37
Warren	21	21	30	30	60	60
Washington	11	107	20	112	46	289
Totals	861	1,538	1,161	1,907	2,497	3,951

Childbearing Women:

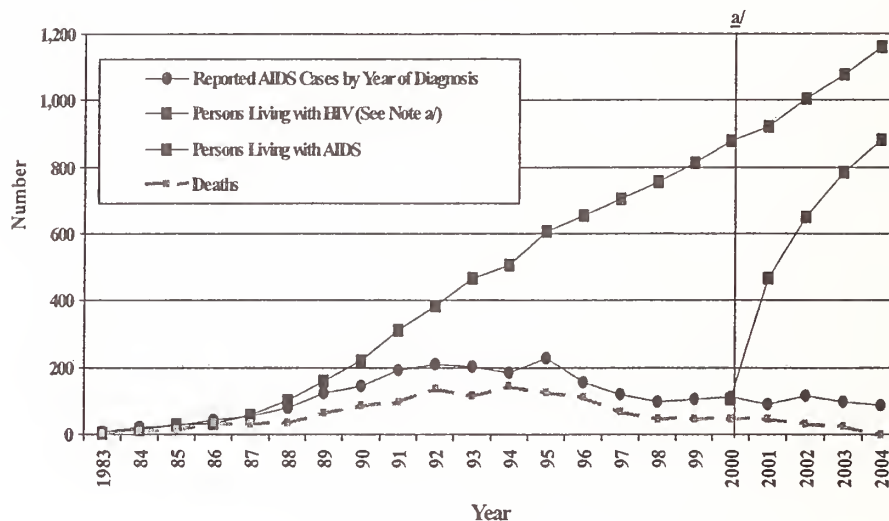
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in the Albany Region had a prevalence of 0.12% (n=17), or approximately 1 in 833 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Albany (Northeastern) Ryan White Region^{1/}

Figure 2

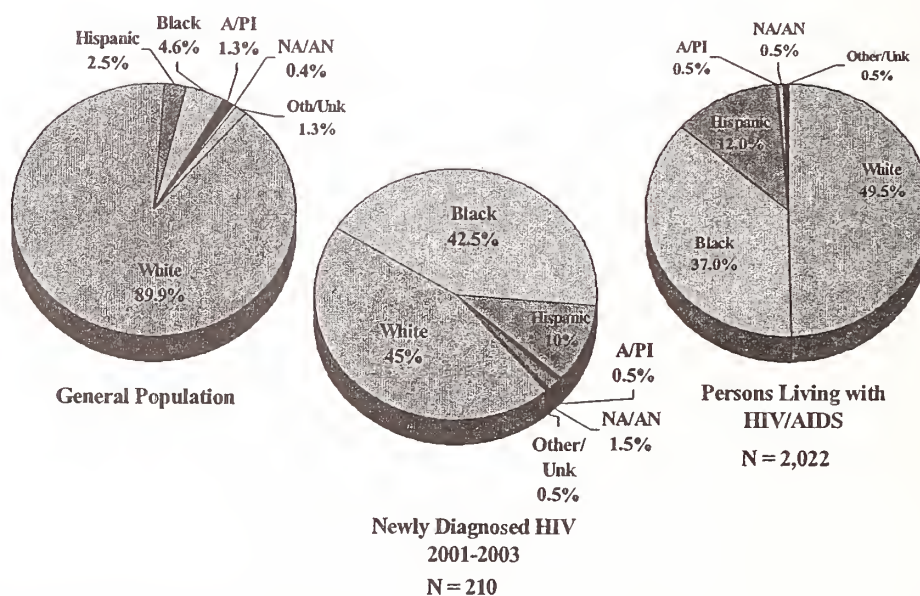
Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*



^{a/} HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
^{b/} Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Excludes Prisoners

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Albany (Northeastern) Ryan White Region^{1/}

Figure 4

**Males* Living with HIV/AIDS
by Race/Ethnicity and Transmission Category**

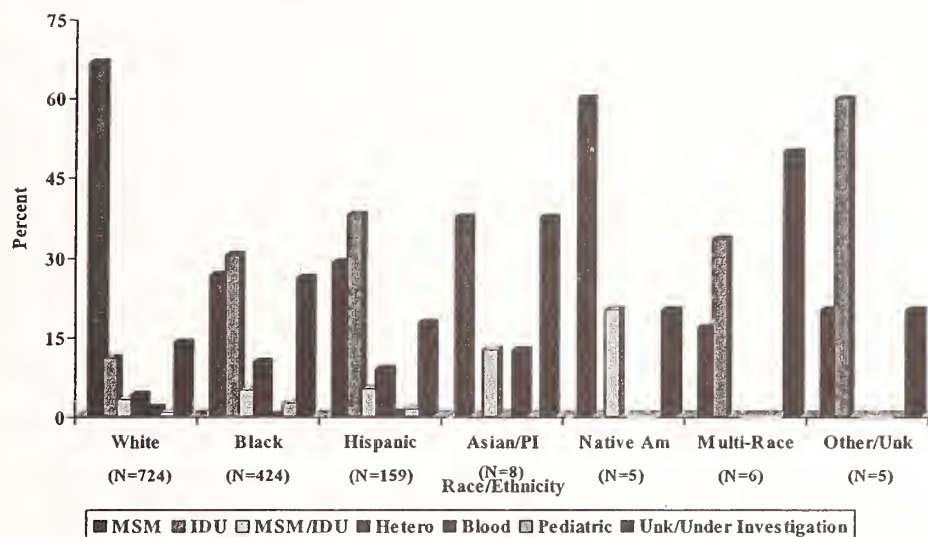
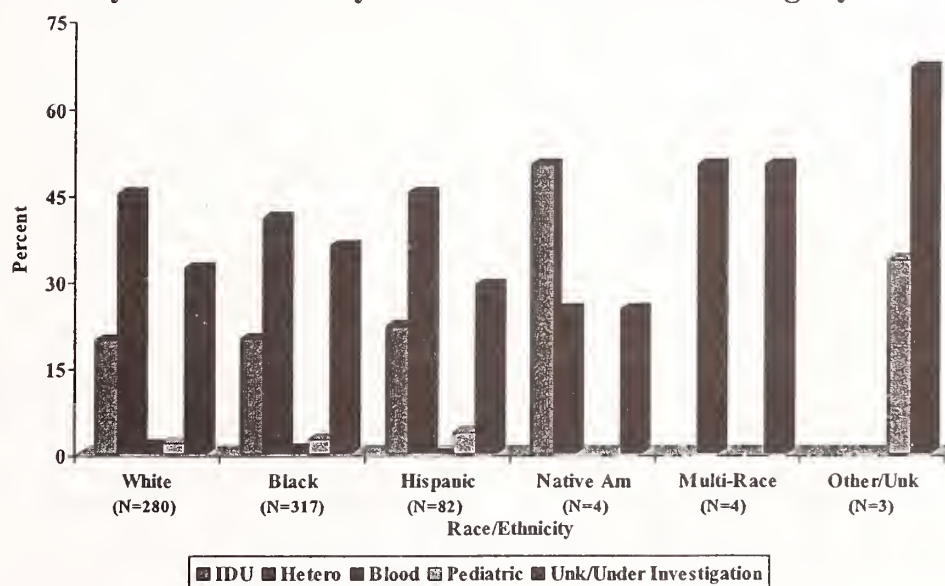


Figure 5

**Females* Living with HIV/AIDS
by Race/Ethnicity** and Transmission Category**



* Excludes Prisoners

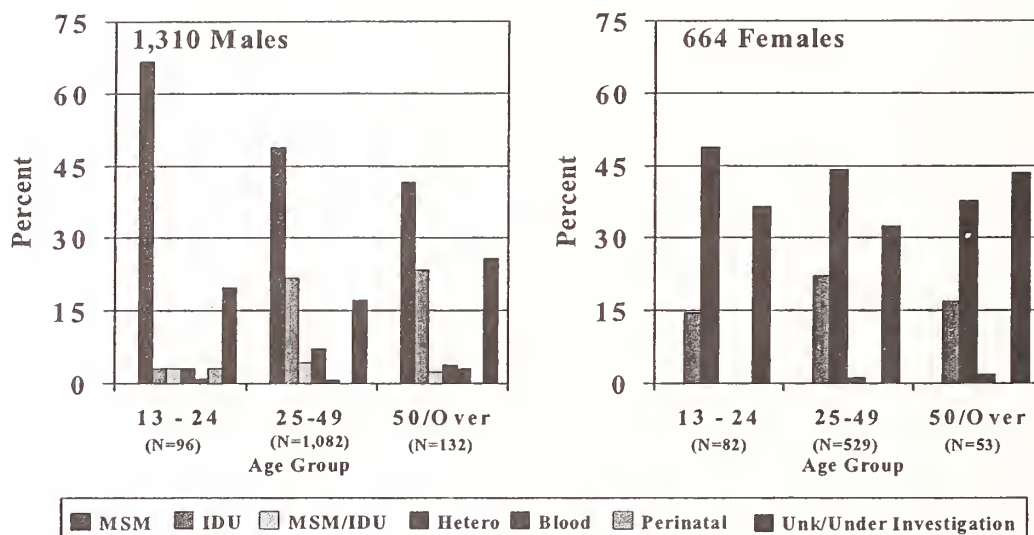
**Asian/Pacific Islander data not included due to small cell sizes

1/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Albany (Northeastern) Ryan White Region^{1/}

Figure 6

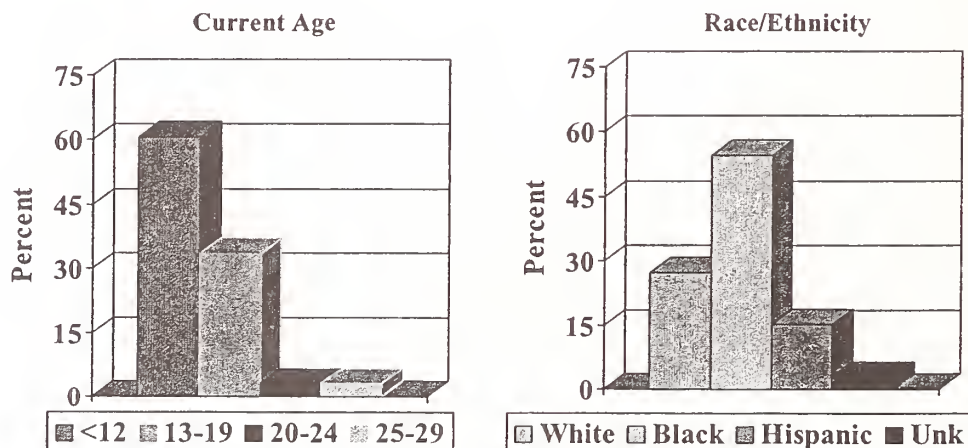
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



*Excludes prisoners; reported cases aged ≥ 13 years with known gender

Figure 7

Persons with Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 33)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Binghamton Tri-County Ryan White Region^{1/}

Figure 1 **Persons Living with HIV and AIDS and Cumulative AIDS Cases**

County of Residence at Time of Diagnosis	Living with HIV Infection		Living with AIDS		Cumulative AIDS Cases	
	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners
Broome	117	120	132	136	271	275
Chenango	14	19	23	32	38	53
Tioga	11	11	11	11	28	28
Totals	142	150	166	179	337	356

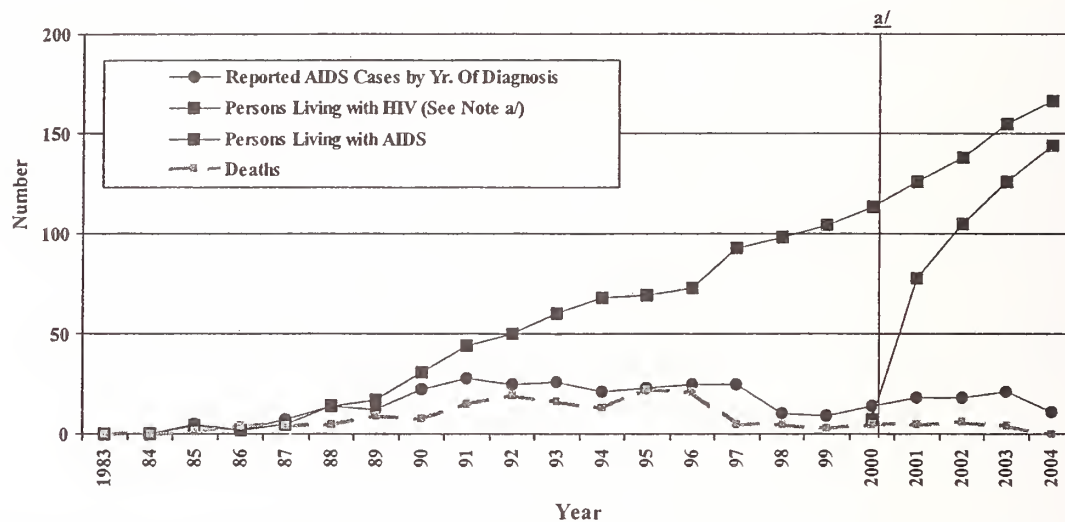
Childbearing Women:

2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in the Binghamton Tri-County Region had a prevalence of 0.14% (n=4), or approximately 1 in 714 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Binghamton Tri-County Ryan White Region ^{1/}

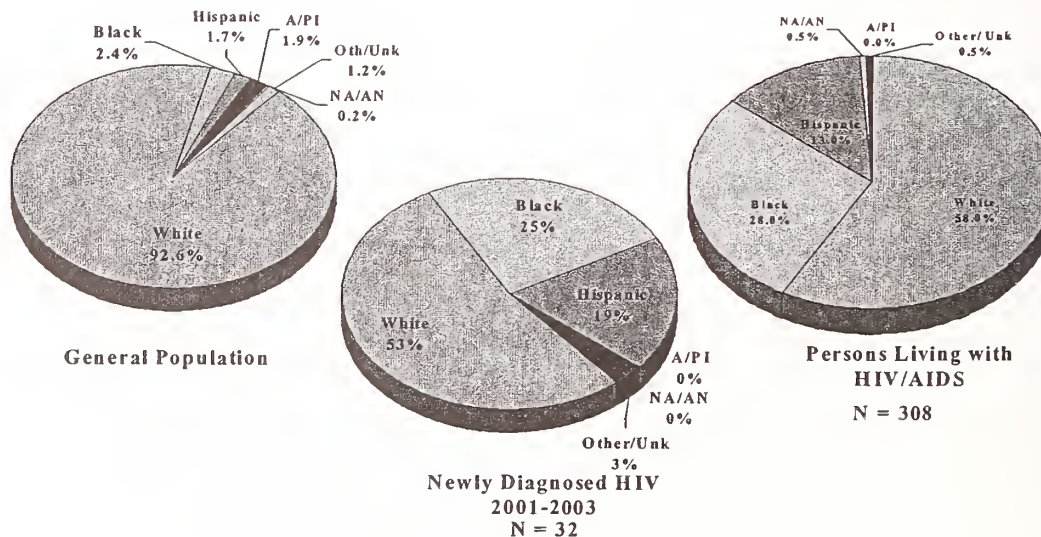
Figure 2 Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.

b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3 Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Excludes Prisoners

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Binghamton Tri-County Ryan White Region^{1/}

Figure 4

Males* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category

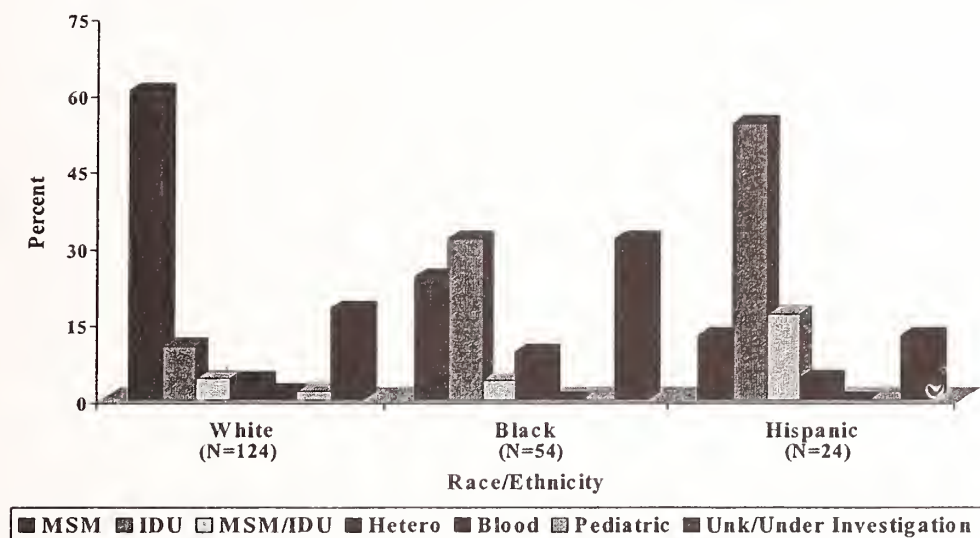
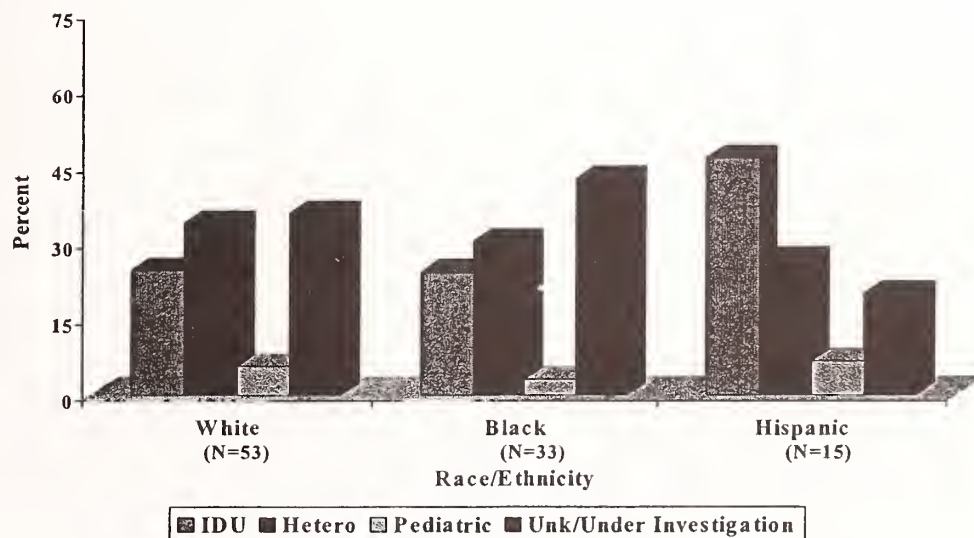


Figure 5

Females* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category



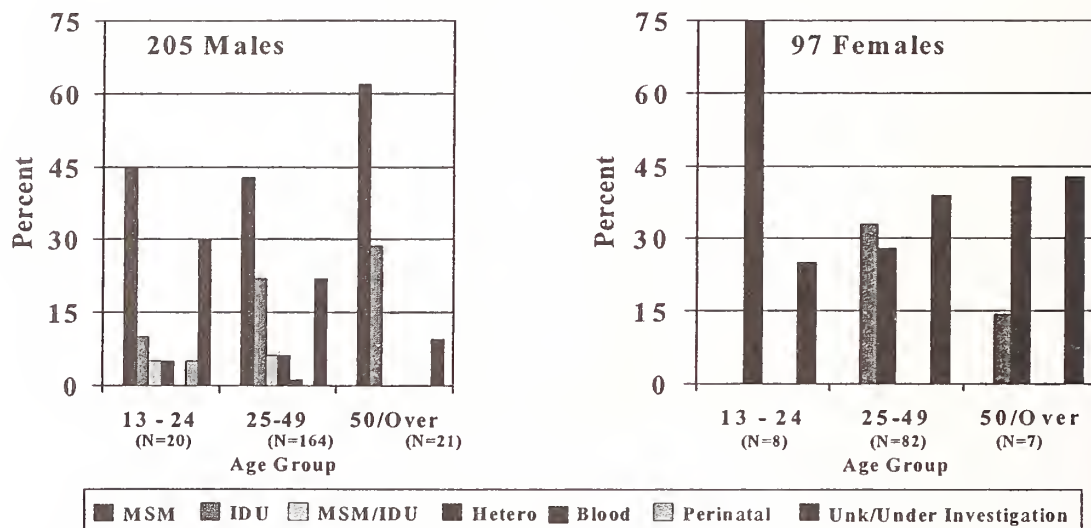
* Excludes Prisoners

**Asian/Pacific Islander, Native American, Multi-Race and Other/Unknown data not included due to small cell sizes

^{1/} Cases reported through December 2004 regardless of diagnosis date.

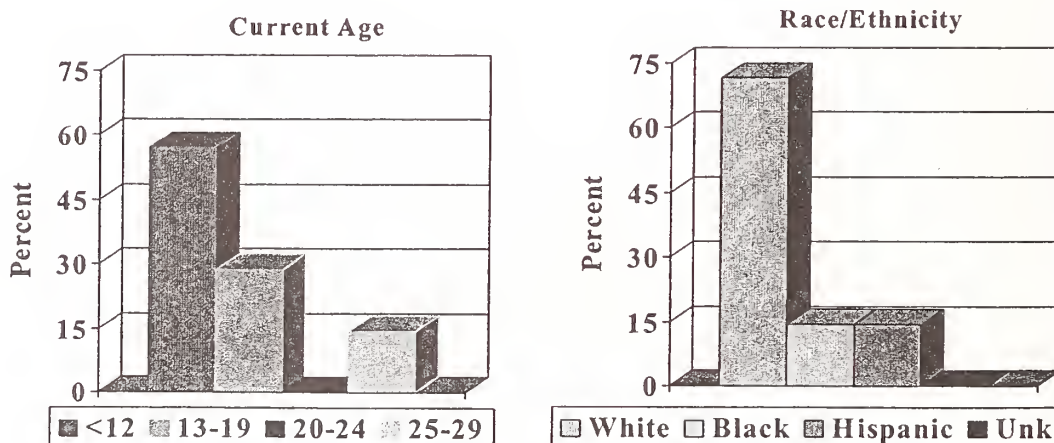
Epidemiologic Profile of Binghamton Tri-County Ryan White Region^{1/}

Figure 6 Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



*Excludes prisoners; reported cases aged ≥ 13 years with known gender.

Figure 7 Persons with Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 7)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Buffalo (Western) Ryan White Region^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases

County of Residence at Time of Diagnosis	Living with HIV Infection		Living with AIDS		Cumulative AIDS Cases	
	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners
Allegany	4	4	8	9	20	21
Cattaraugus	19	59	20	45	44	74
Chautauqua	56	112	63	80	113	135
Erie	553	646	799	901	1,821	2,017
Genesee	15	15	21	23	43	45
Niagara	50	53	77	81	211	215
Orleans	11	251	24	236	41	357
Wyoming	6	119	9	152	17	309
Totals	714	1,259	1,021	1,527	2,310	3,173

Childbearing Women:

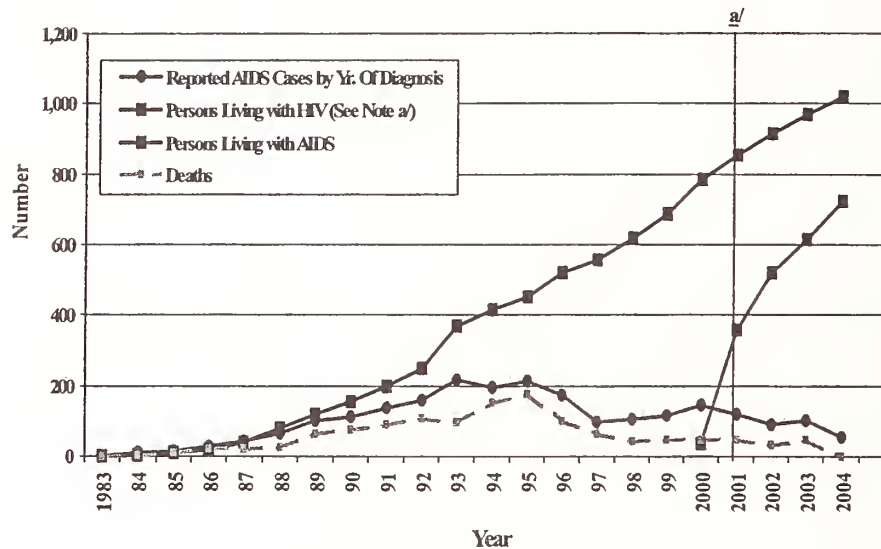
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in the Buffalo Region had a prevalence of 0.14% (n=24), or approximately 1 in 714 women giving birth had a positive HIV test result.

1/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Buffalo (Western) Ryan White Region^{1/}

Figure 2

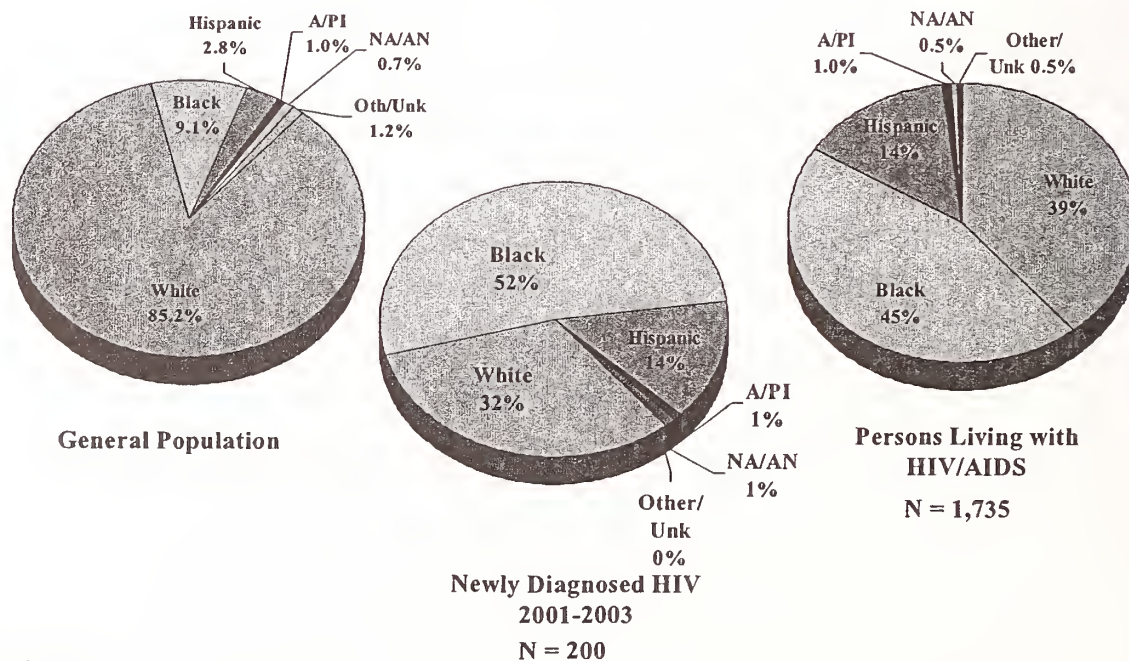
Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Excludes prisoners.

1/ Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Buffalo (Western) Ryan White Region^{1/}

Figure

Males* Living with HIV/AIDS by Race/Ethnicity and Transmission Category

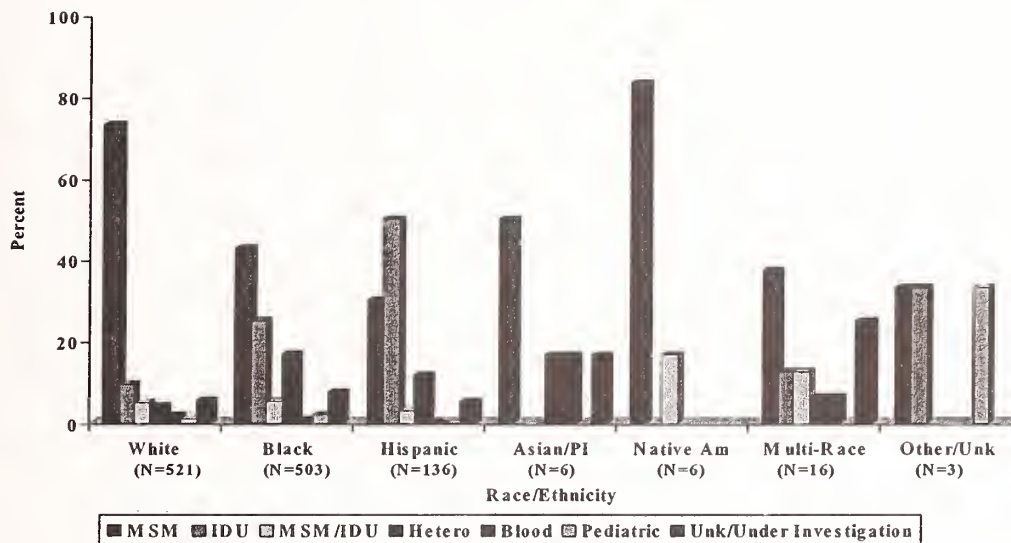
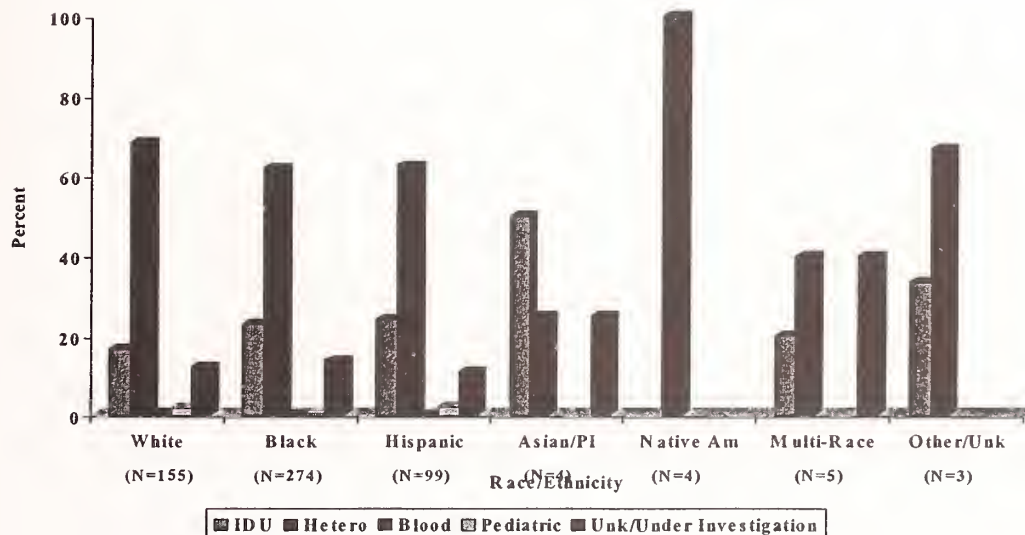


Figure 5

Females* Living with HIV/AIDS by Race/Ethnicity and Transmission Category



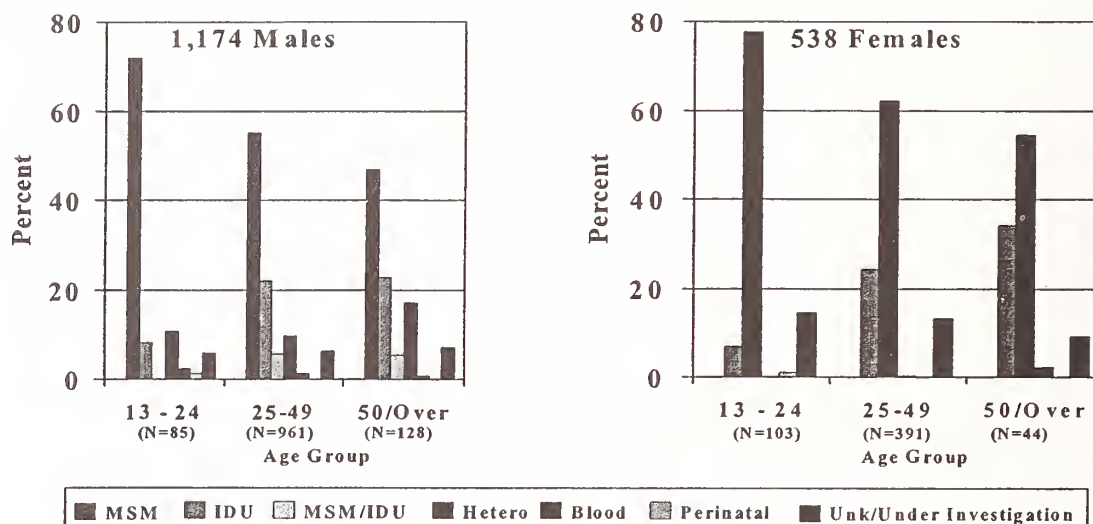
* Excludes Prisoners.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Buffalo (Western) Ryan White Region^{1/}

Figure 6

Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons with Maternally Transmitted HIV/AIDS by
Current Age and Race/Ethnicity (N = 22)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Lower Hudson Ryan White Region^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases

County of Residence at Time of Diagnosis	Living with HIV Infection		Living with AIDS		Cumulative AIDS Cases	
	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners
Putnam	26	27	73	74	167	168
Rockland	156	159	399	464	864	931
Westchester	827	1,097	1,947	2,221	4,498	4,983
Totals	1,009	1,283	2,419	2,759	5,529	6,082

Childbearing Women:

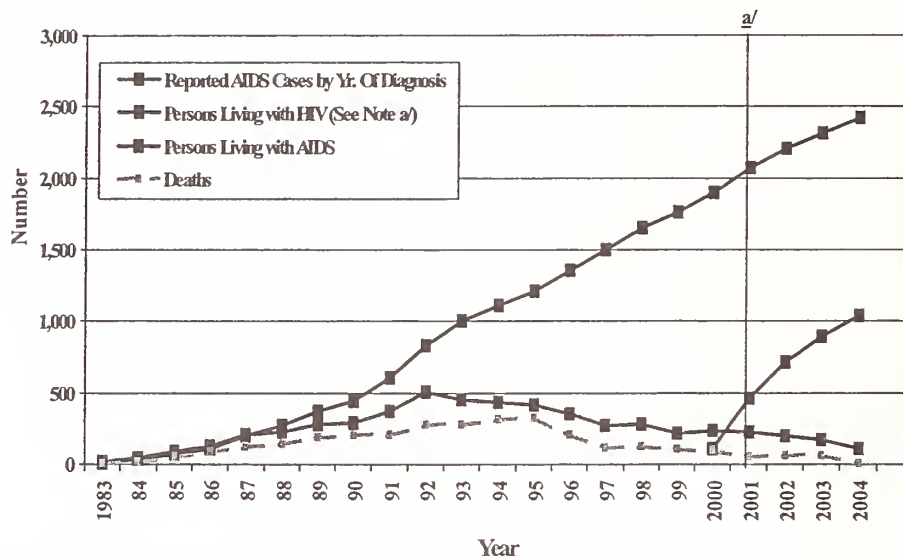
2004 data from the NYS Comprehensive Newborn Screening Program notes that women giving birth in the Lower Hudson Region had a prevalence of 0.15% (n=25), or approximately 1 in 666 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Lower Hudson Ryan White Region^{1/}

Figure 2

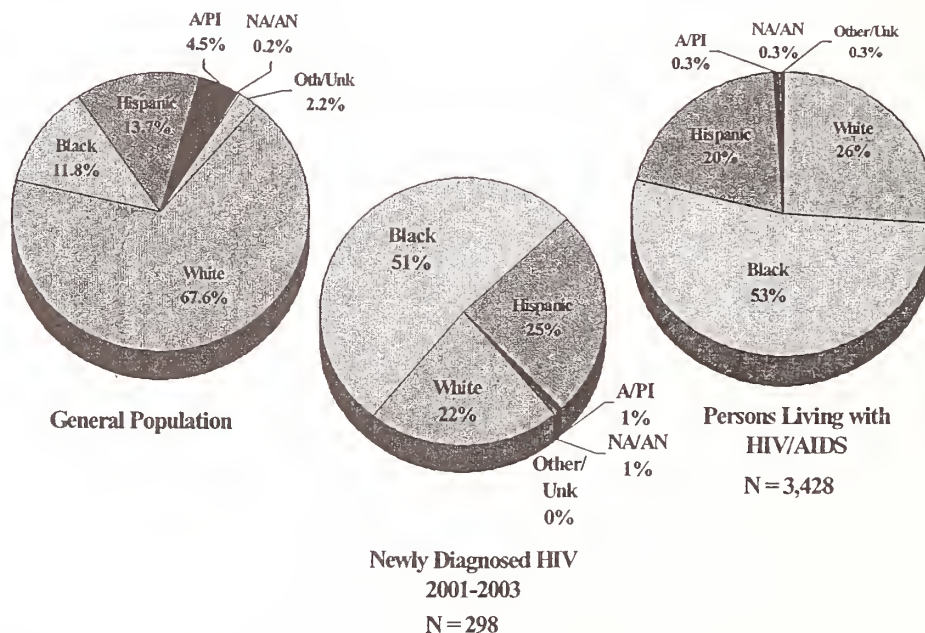
Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



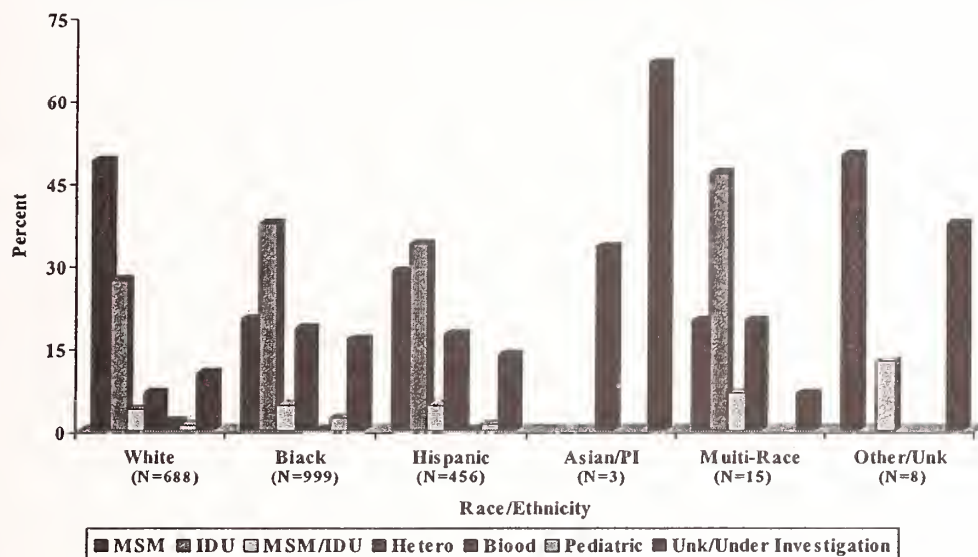
* Excludes prisoners.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Lower Hudson Ryan White Region^{1/}

Figure 4

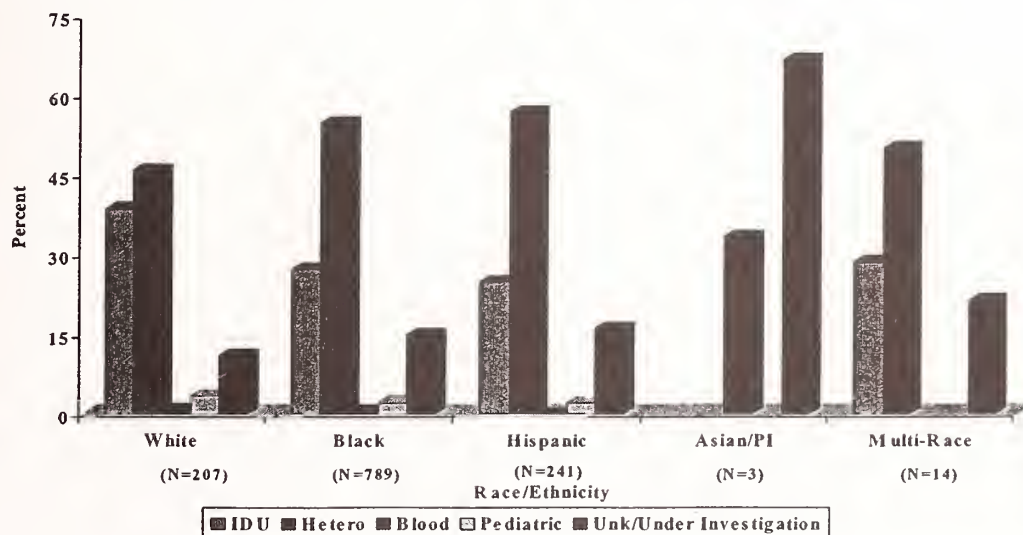
Males* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category



**Native American data not included due to small cell sizes

Figure 5

Females* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category



* Excludes Prisoners.

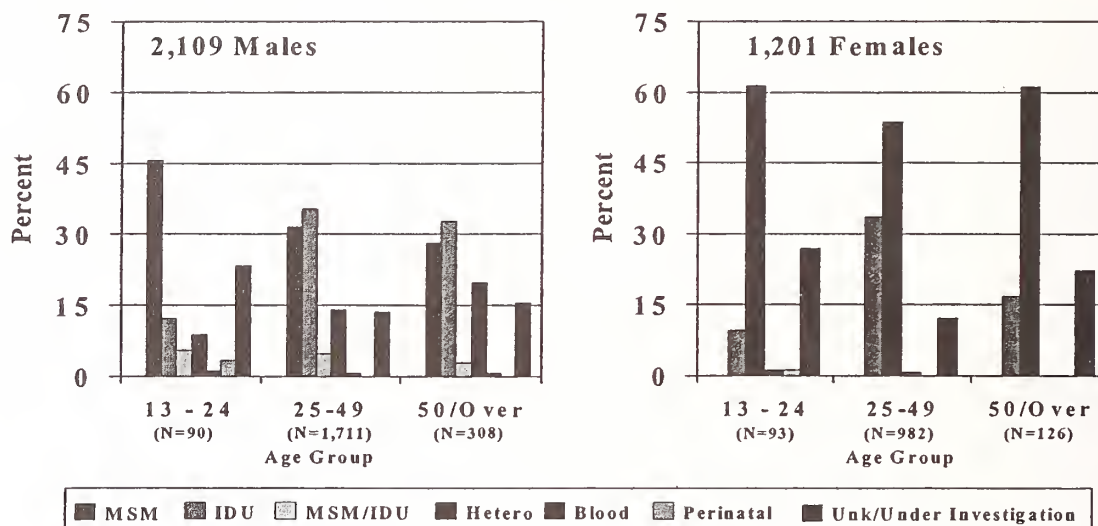
** Native American data not included due to small cell sizes. There are no Other/Unknown cases.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Lower Hudson Ryan White Region^{1/}

Figure 6

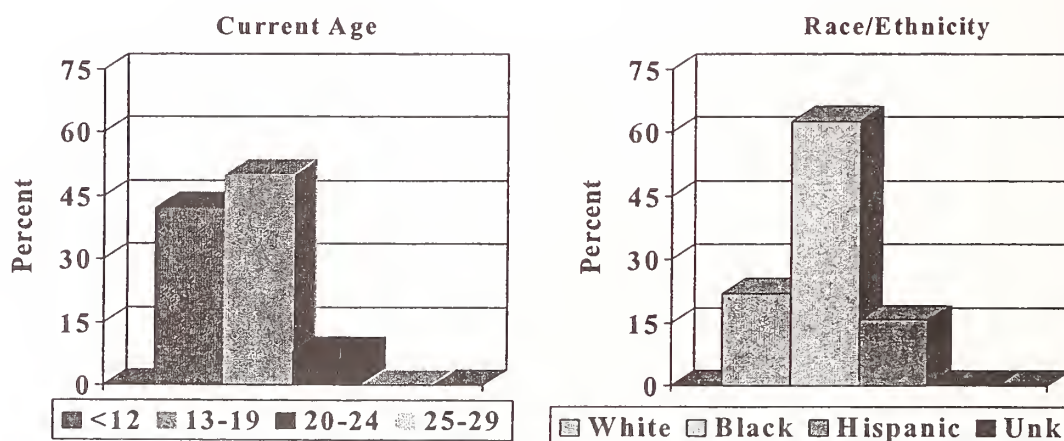
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons with Maternally Transmitted HIV/AIDS by
Current Age and Race/Ethnicity (N = 64)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Mid-Hudson Ryan White Region^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases

County of Residence at Time of Diagnosis	Living with HIV Infection		Living with AIDS		Cumulative AIDS Cases	
	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners
Dutchess	206	397	374	666	892	1,534
Orange	229	318	479	607	1,102	1,328
Sullivan	125	187	185	261	477	631
Ulster	125	237	260	428	593	896
Total	685	1,139	1,298	1,962	3,064	4,389

Childbearing Women:

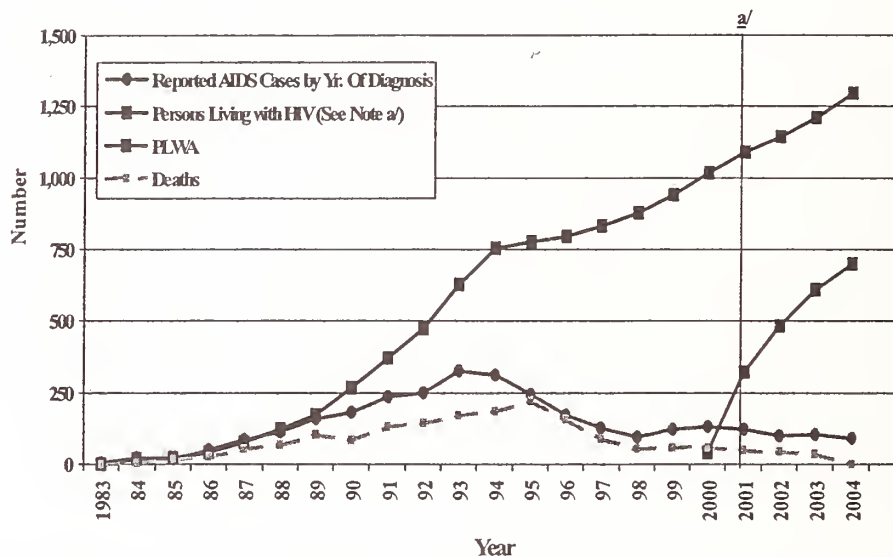
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in the Mid-Hudson Region had a prevalence of 0.17% (n=17), or approximately 1 in 588 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Mid-Hudson Ryan White Region^{1/}

Figure 2

Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{1/} 1983 through 2004*

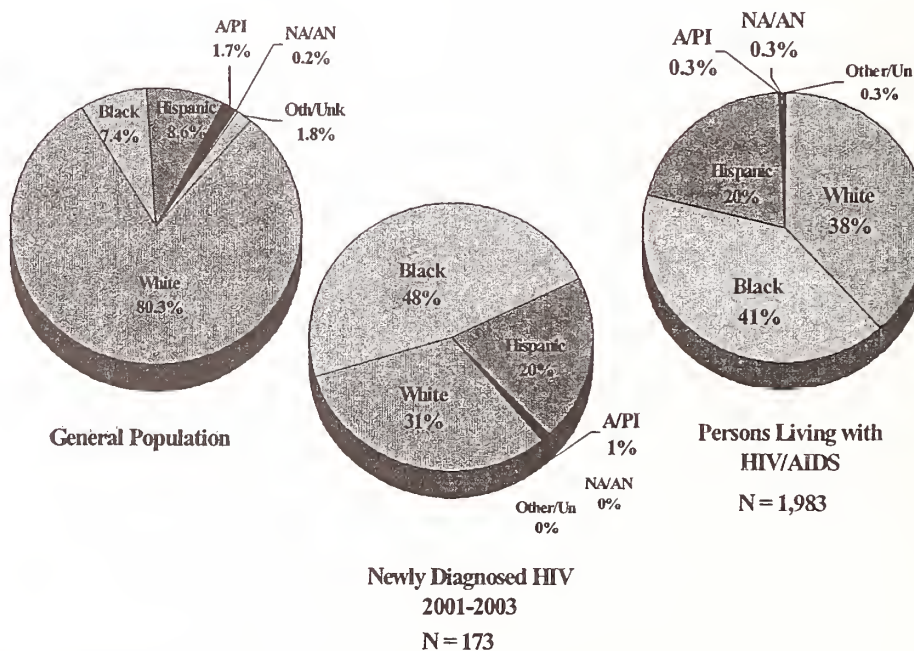


a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.

b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*

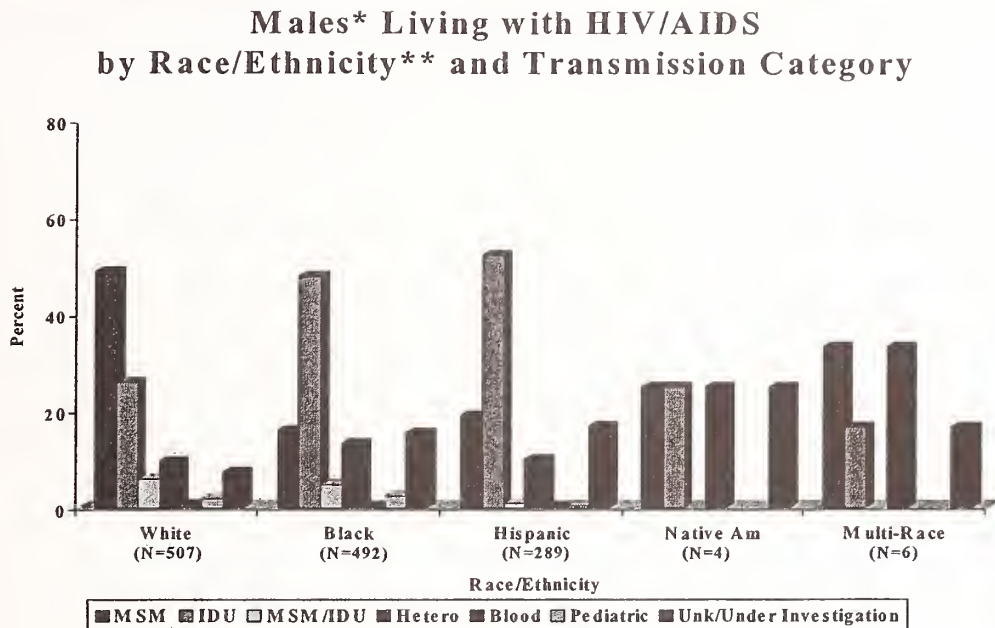


* Excludes prisoners.

1/ Cases reported through December 2004 regardless of diagnosis date.

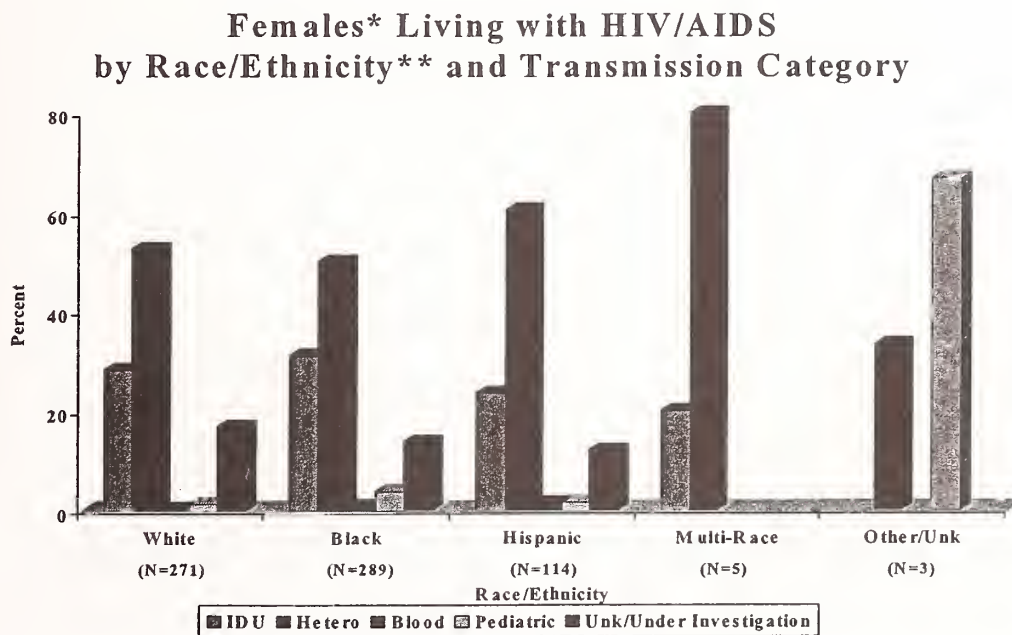
Epidemiologic Profile of Mid-Hudson Ryan White Region ^{1/}

Figure 4



**Asian/Pacific Islander data not included due to small cell sizes; there were no Other/Unknown cases.

Figure 5



** Asian/Pacific Islander data not included due to small cell sizes; there were no Native American cases.

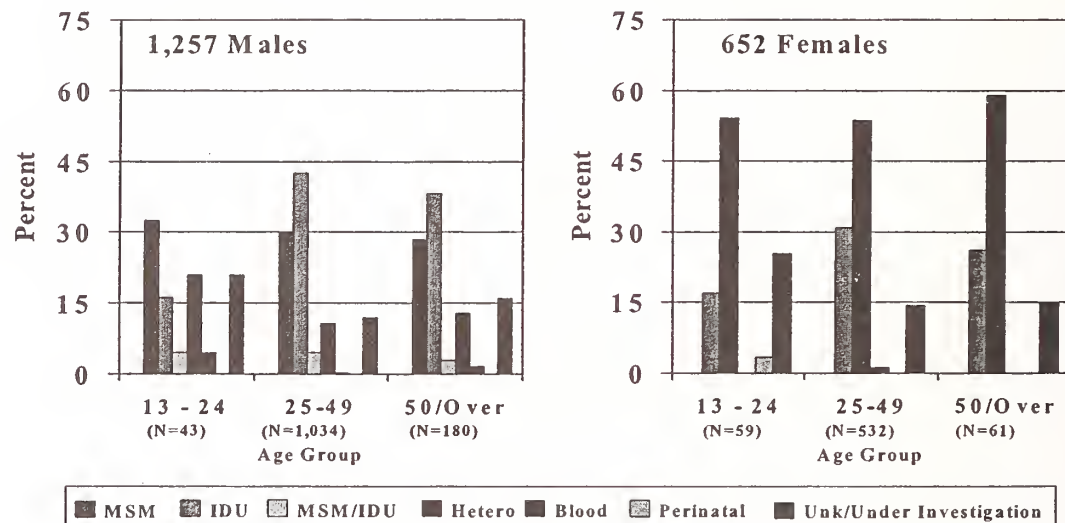
* Excludes Prisoners

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Mid-Hudson Ryan White Region^{1/}

Figure 6

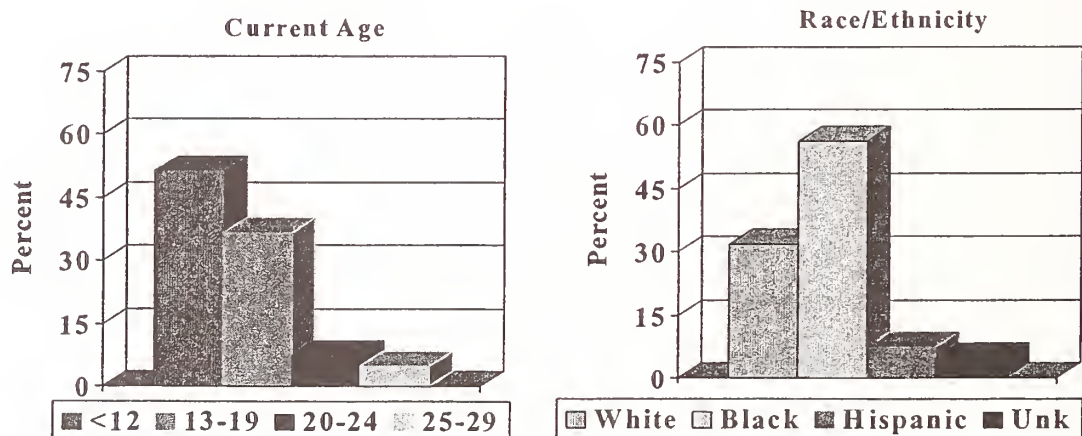
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons with Maternally Transmitted HIV/AIDS by
Current Age and Race/Ethnicity (N = 41)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Nassau/Suffolk Ryan White Region ^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases

County of Residence at Time of Diagnosis	Living with HIV Infection		Living with AIDS		Cumulative AIDS Cases	
	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners
Nassau	686	709	1,507	1,533	3,765	3,812
Suffolk	745	764	1,498	1,525	3,712	3,772
Total	1,431	1,473	3,005	3,058	7,477	7,584

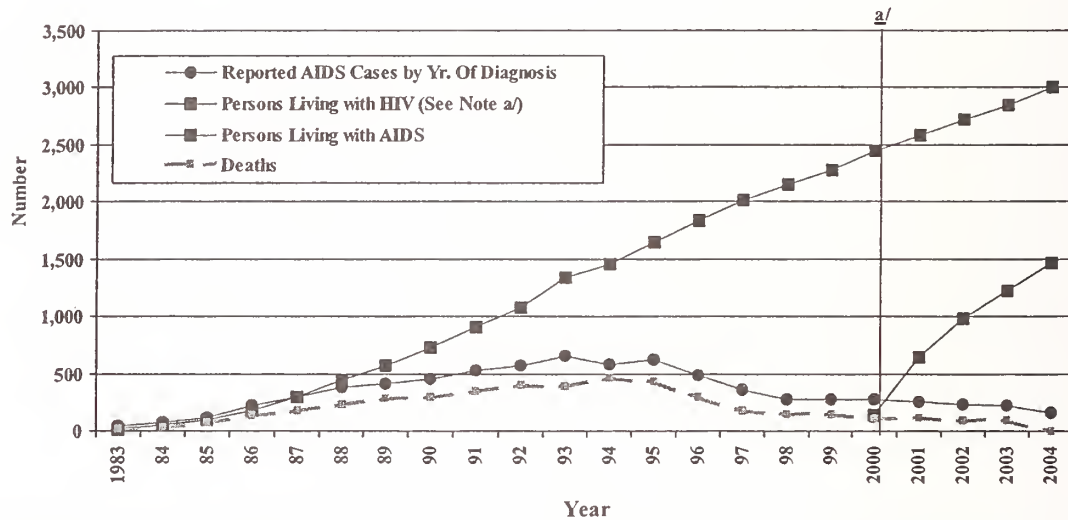
Childbearing Women:

2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in the Nassau/Suffolk Region had a prevalence of 0.09% (n=31), or approximately 1 in 1,111 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Nassau/Suffolk Ryan White Region^{1/}

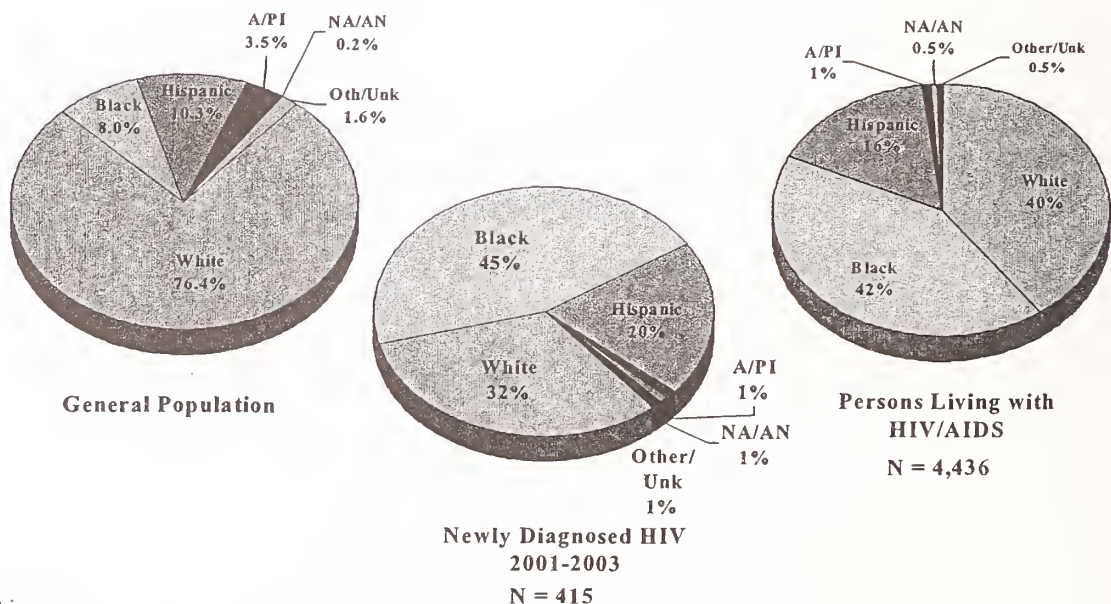
Figure 2 Reported AIDS Cases, Persons Living with HIV, Persons Living with AIDS, and Deaths^{b/} 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed HIV and Persons Living with HIV and AIDS*



* Excludes Prisoners

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Nassau/Suffolk Ryan White Region^{1/}

Figure 4

Males* Living with HIV/AIDS by Race/Ethnicity and Transmission Category

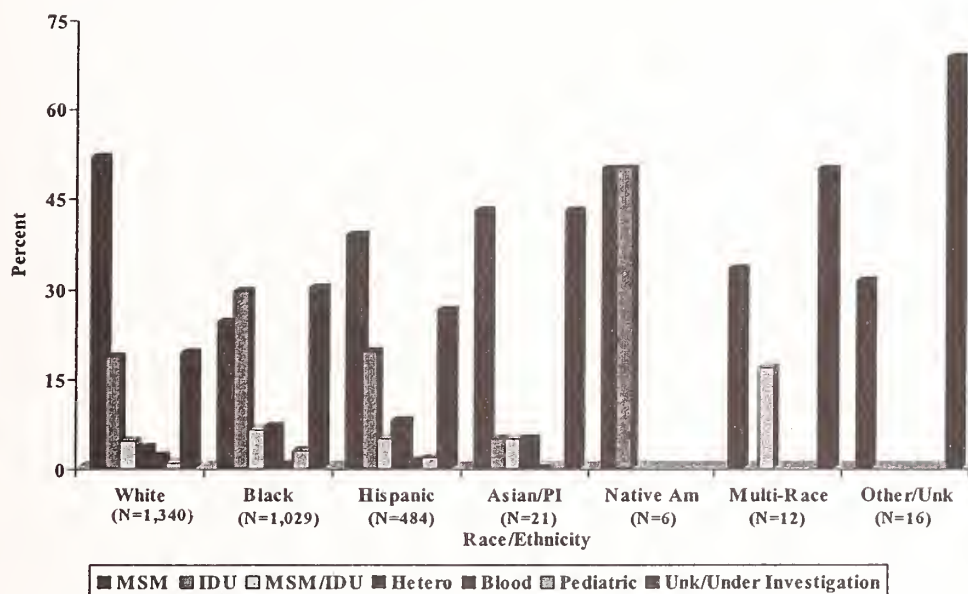
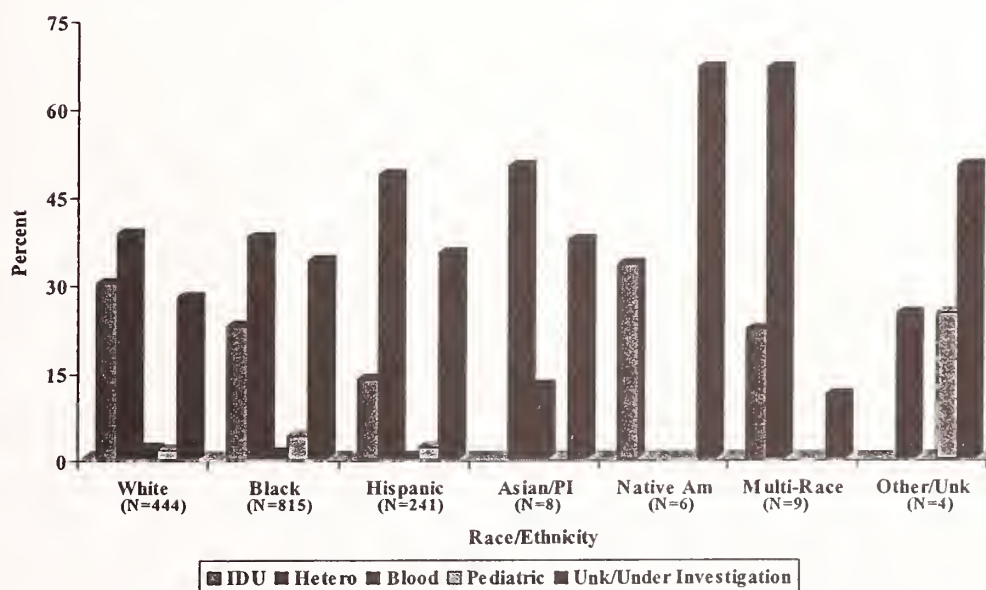


Figure 5

Females* Living with HIV/AIDS by Race/Ethnicity and Transmission Category

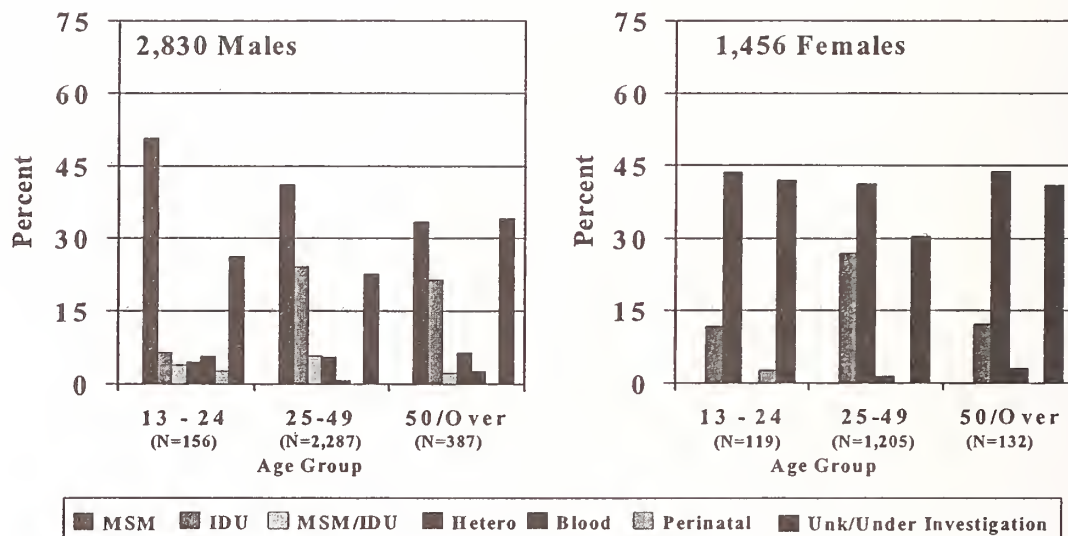


* Excludes Prisoners

^{1/} Cases reported through December 2004 regardless of diagnosis date.

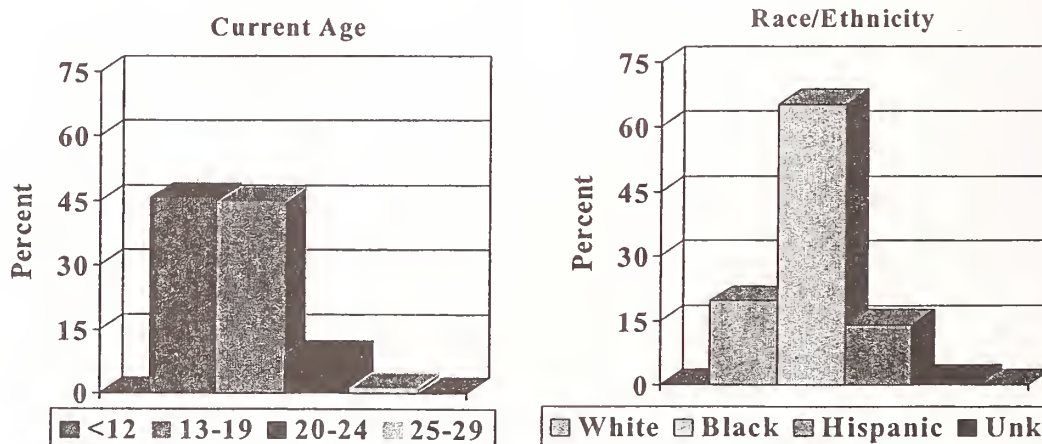
Epidemiologic Profile of Nassau/Suffolk Ryan White Region^{1/}

Figure 6 Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



*Excludes prisoners; reported cases aged ≥ 13 years with known gender

Figure 7 Persons with Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N=92)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Rochester (Finger Lakes) Ryan White Region^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases

County of Residence at Time of Diagnosis	Living with HIV Infection		Living with AIDS		Cumulative AIDS Cases	
	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners
Chemung	31	81	34	95	115	251
Livingston	15	101	31	103	67	201
Monroe	609	638	988	1,007	2,077	2,111
Ontario	20	21	35	36	57	58
Schuyler	2	7	2	4	12	14
Seneca	11	115	9	58	21	75
Steuben	17	19	26	26	72	72
Wayne	35	46	35	48	82	100
Yates	7	7	2	2	9	9
Totals	747	1,035	1,162	1,379	2,512	2,891

Childbearing Women:

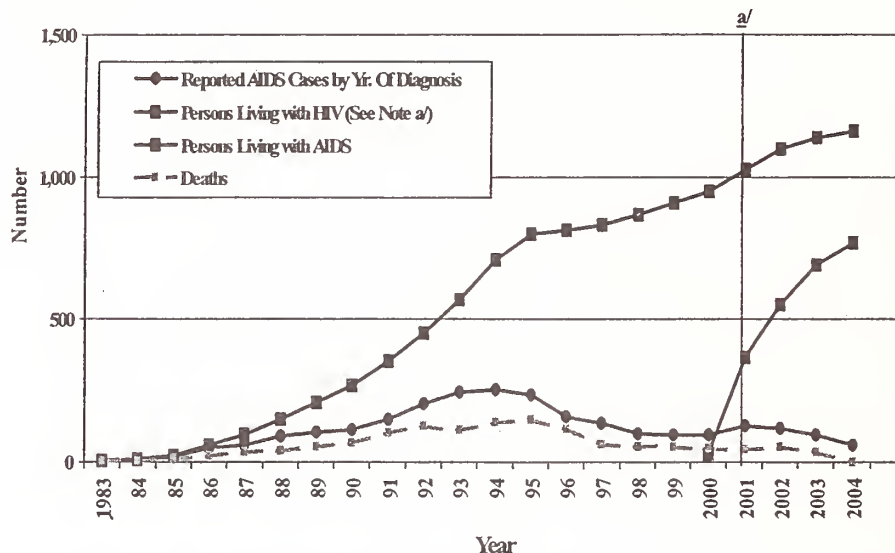
2002 data from the NYS Comprehensive Newborn Screening Program indicate that women giving birth in the Rochester Region had a prevalence of 0.11% (n=15), or approximately 1 in 909 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Rochester (Finger Lakes) Ryan White Region ^{1/}

Figure 2

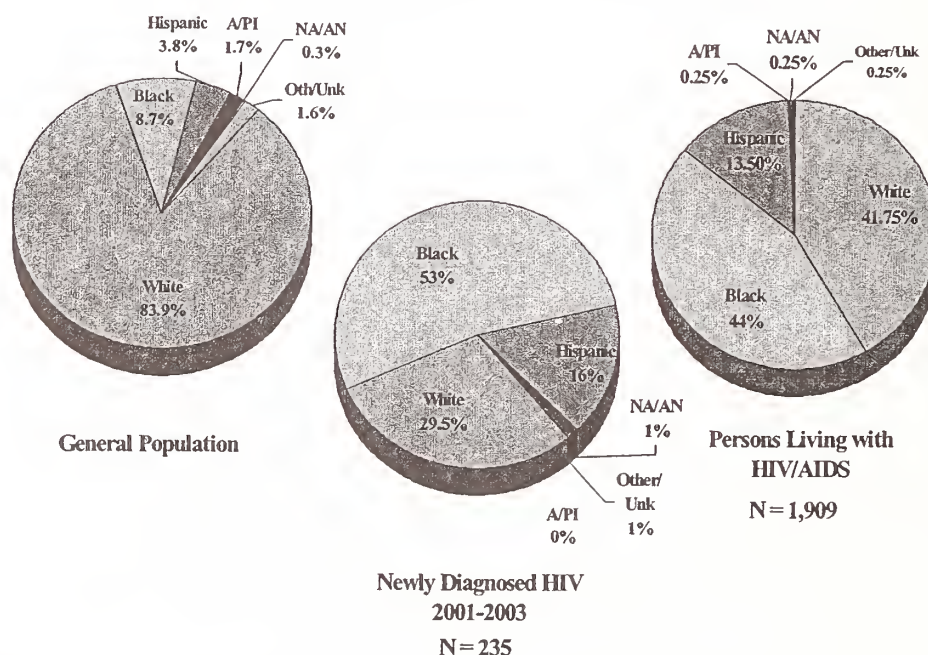
Reported AIDS Cases, Persons Living with HIV, Persons
Living with AIDS, and Deaths^{b/} 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed
HIV and Persons Living with HIV and AIDS*



* Excludes prisoners.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Rochester (Finger Lakes) Ryan White Region^{1/}

Figure 4

Males* Living with HIV/AIDS by Race/Ethnicity and Transmission Category

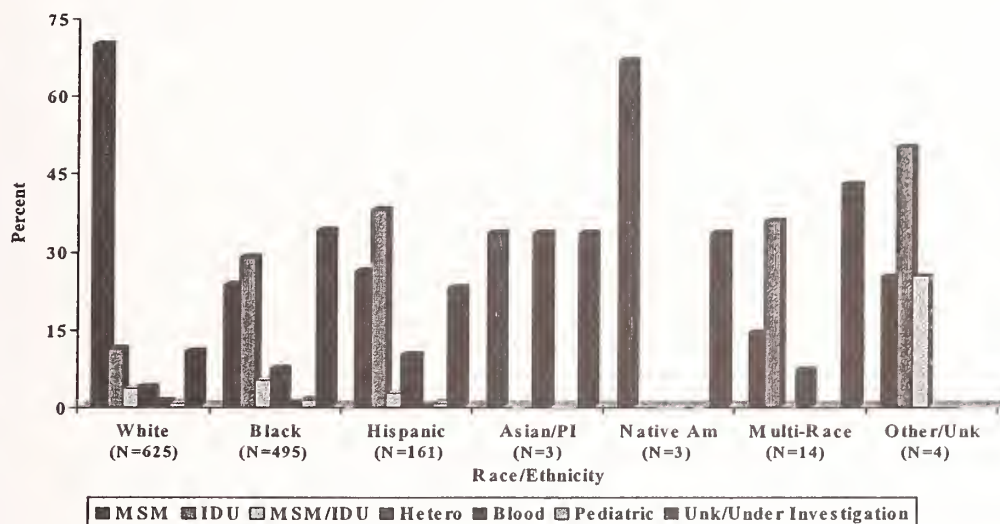
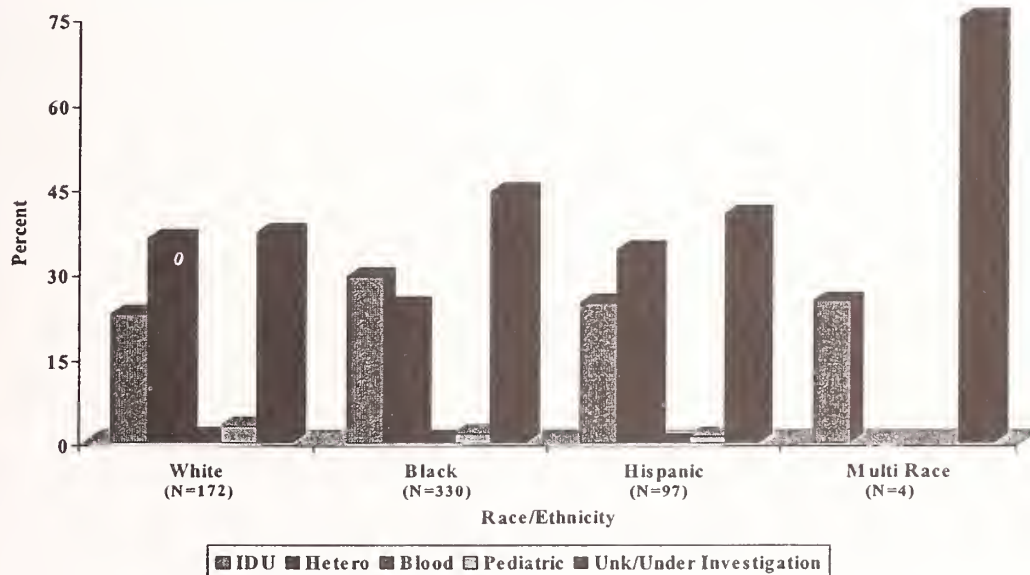


Figure 5

Females* Living with HIV/AIDS by Race/Ethnicity** and Transmission Category



* Excludes Prisoners

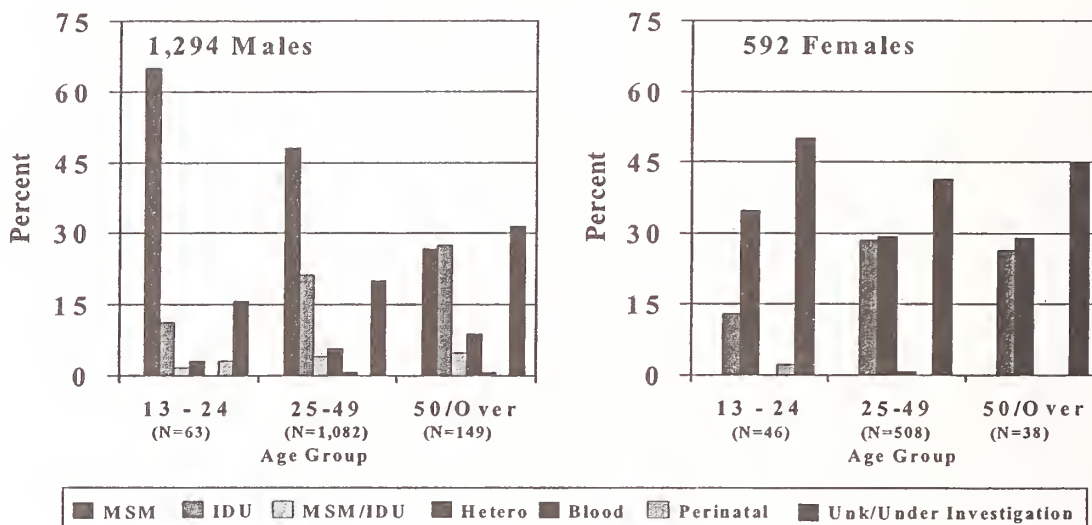
** Asian/Pacific Islander, Native American and Other/Unknown data not included due to small cell sizes.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Rochester (Finger Lakes) Ryan White Region^{1/}

Figure 6

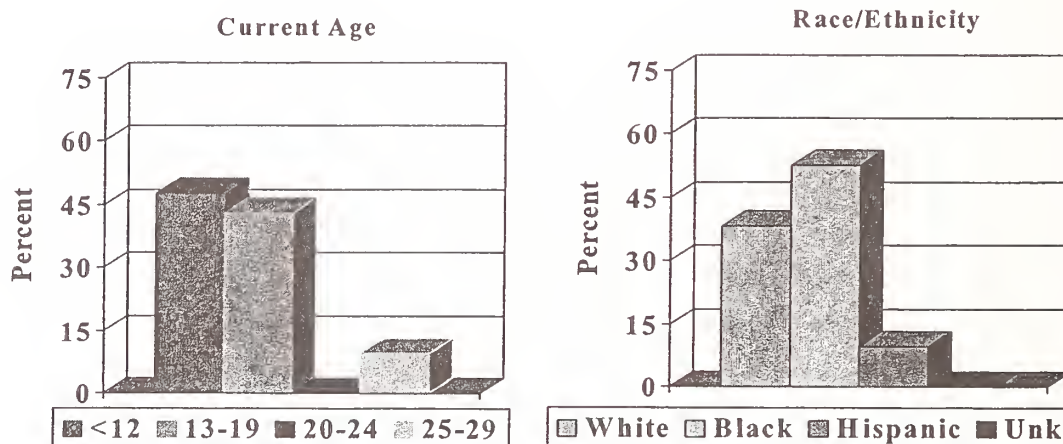
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

Persons with Maternally Transmitted HIV/AIDS by Current Age and Race/Ethnicity (N = 21)



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Syracuse Ryan White Region ^{1/}

Figure 1

Persons Living with HIV and AIDS and Cumulative AIDS Cases

County of Residence at Time of Diagnosis	Living with HIV Infection		Living with AIDS		Cumulative AIDS Cases	
	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners	Excluding Prisoners	Including Prisoners
Cayuga	19	105	44	142	79	293
Cortland	6	6	9	9	21	21
Herkimer	14	14	14	14	32	32
Jefferson	26	197	37	171	73	282
Lewis	21	21	5	6	11	12
Madison	12	13	15	27	34	50
Oneida	108	367	163	480	350	923
Onondaga	285	293	479	490	1,061	1,077
Oswego	21	21	42	42	83	83
St. Lawrence	31	194	45	201	73	310
Tompkins	19	20	62	65	119	122
Totals	562	1,251	915	1,647	1,936	3,205

Childbearing Women:

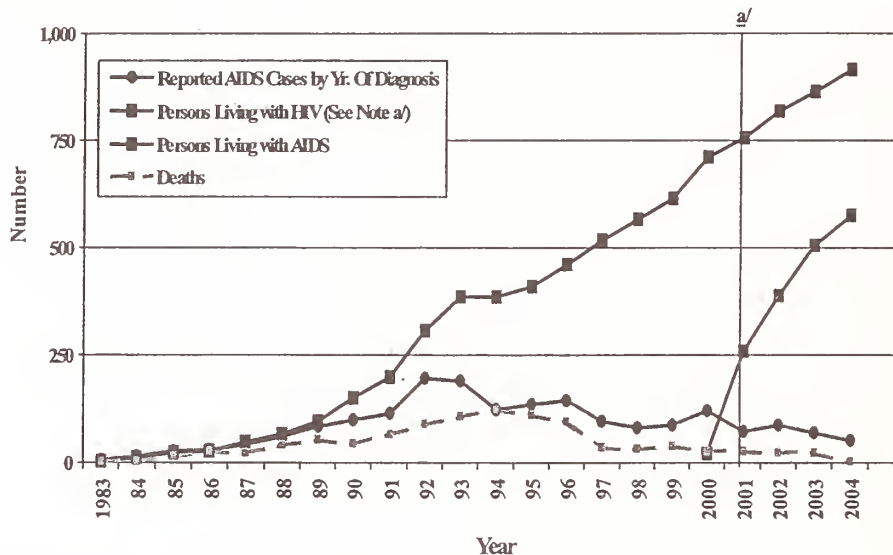
2002 data from the NYS Comprehensive Newborn Screening Program indicates that women giving birth in the Syracuse Region had a prevalence of 0.07% (n=11), or approximately 1 in 1,429 women giving birth had a positive HIV test result.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Syracuse Ryan White Region^{1/}

Figure 2

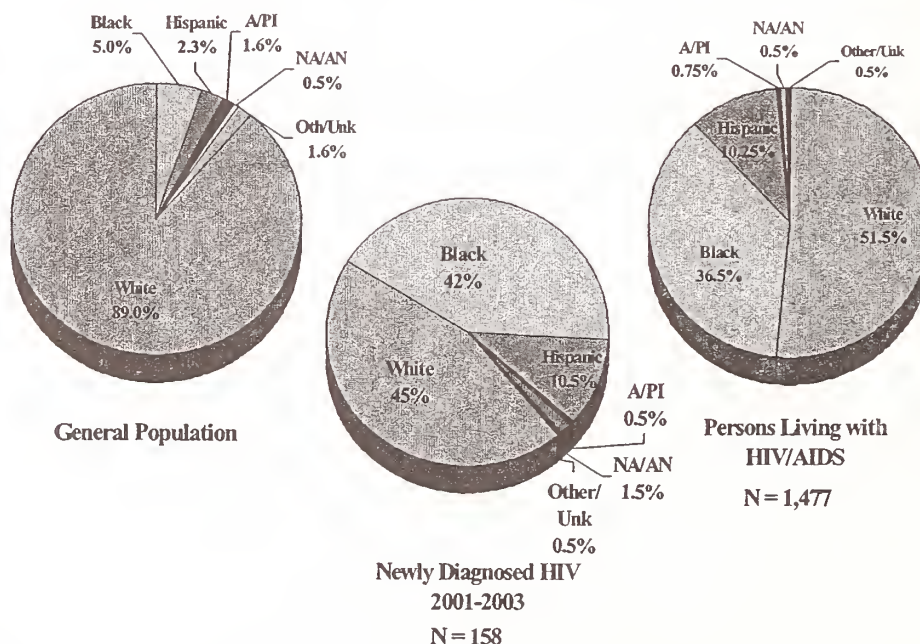
Reported AIDS Cases, Persons Living with HIV, Persons
Living with AIDS, and Deaths^{b/} 1983 through 2004*



a/ HIV named reporting in NYS started in 2000. This graph reflects the number of persons living with HIV who had been reported by the end of the year.
b/ Deaths from any cause for Persons with HIV/AIDS

Figure 3

Population Comparison: General Population, Newly Diagnosed
HIV and Persons Living with HIV and AIDS*



* Excludes prisoners.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Syracuse Ryan White Region^{1/}

Figure 4

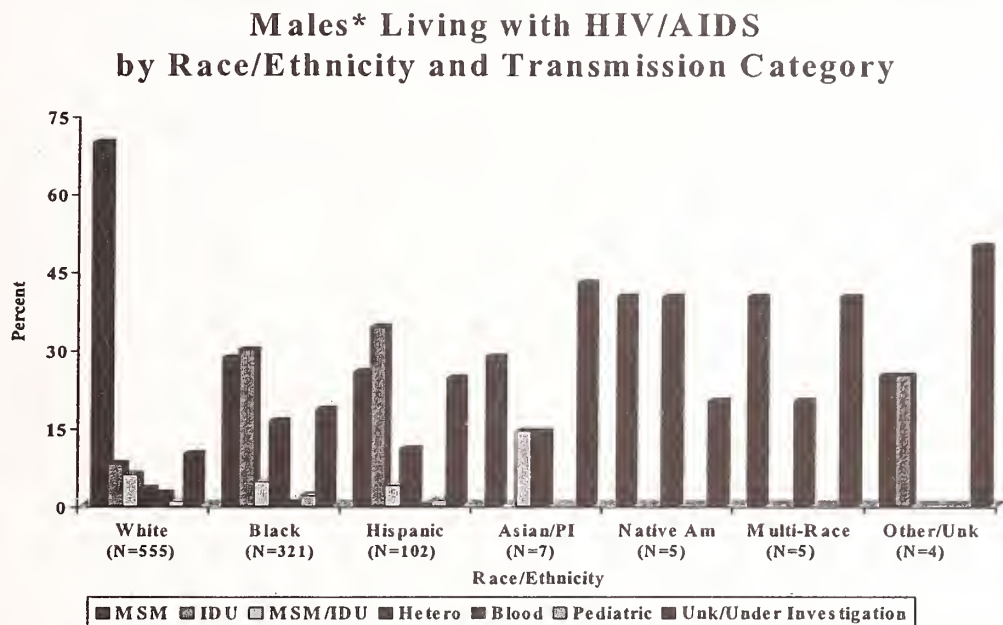
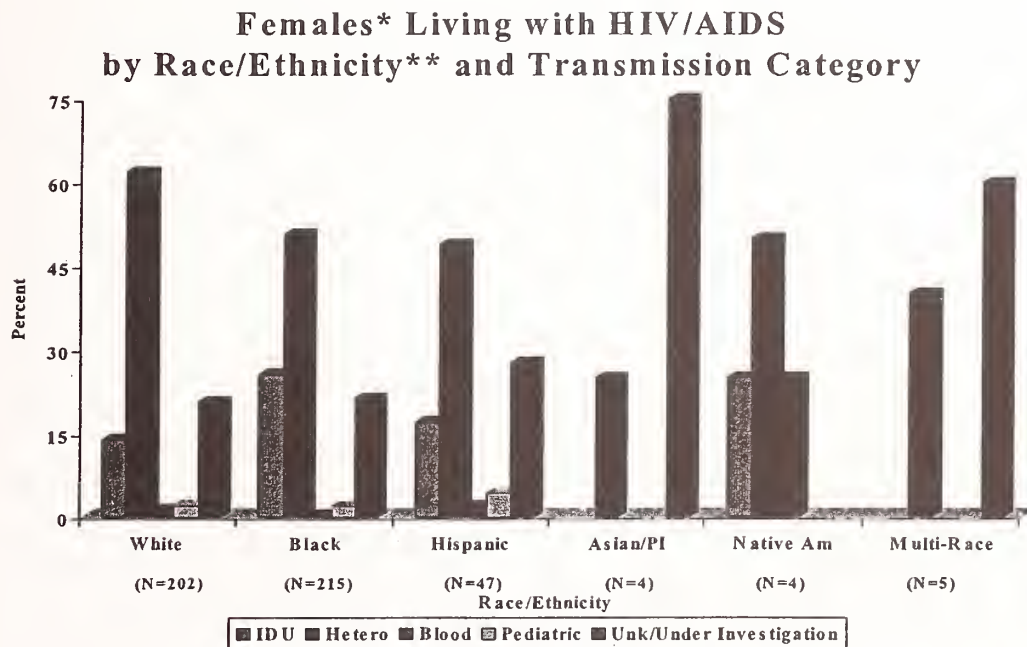


Figure 5



* Excludes Prisoners

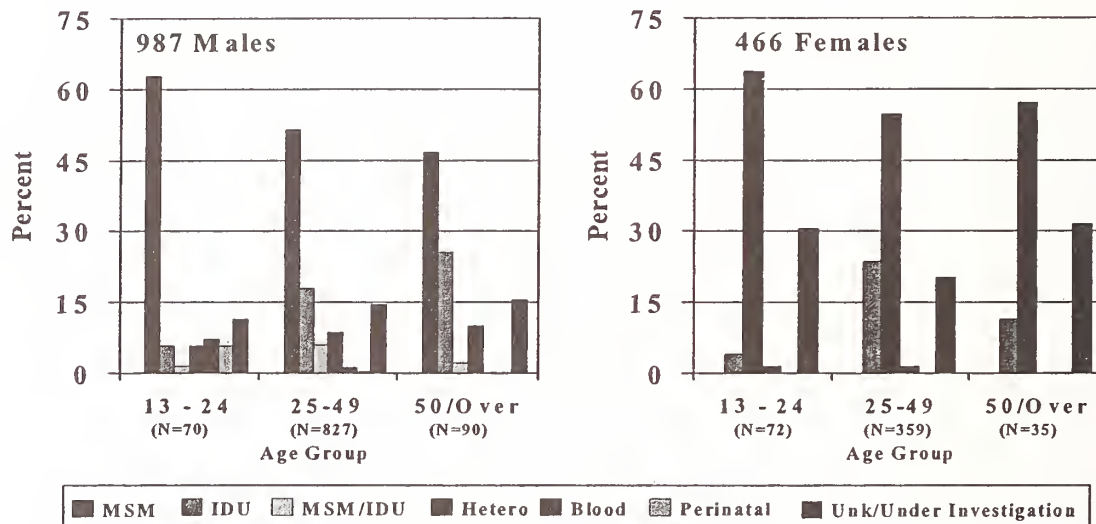
** Other/Unknown data not included due to small cell size.

^{1/} Cases reported through December 2004 regardless of diagnosis date.

Epidemiologic Profile of Syracuse Ryan White Region^{1/}

Figure 6

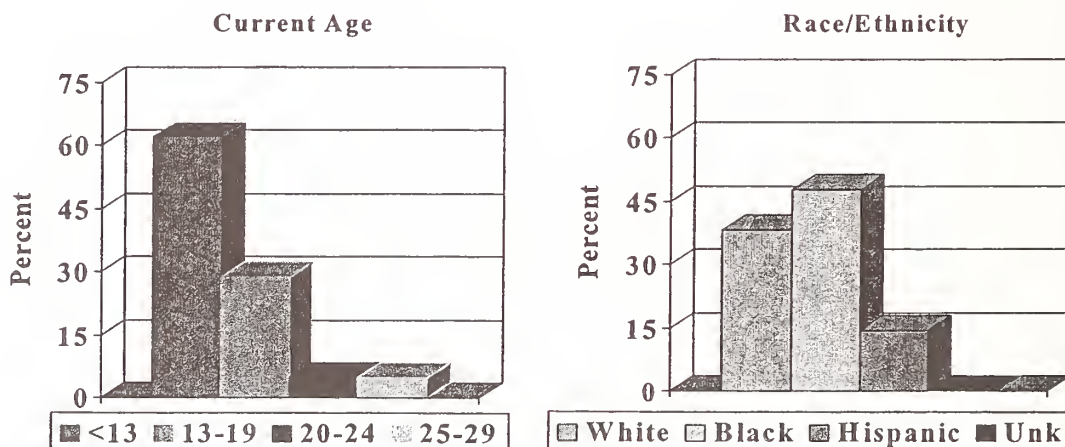
Persons* with HIV and AIDS by Gender, Transmission Category and Age Group



* Excludes prisoners; reported cases ages ≥ 13 years with known gender.

Figure 7

**Persons with Maternally Transmitted HIV/AIDS by
Current Age and Race/Ethnicity (N = 21)**



^{1/} Cases reported through December 2004 regardless of diagnosis date.

Data Interpretation



Examples for Use with Question 2 Data and Materials

The following section begins to describe the HIV/AIDS epidemic in NYS in greater detail. Tables, such as the one following this paragraph, are cross tabulations that allow more than one category to be described. This section also includes line and bar graphs, area graphs, and pie charts. Two data displays, a table and a chart, are discussed in detail and serve as a model of how to pull information from a presentation. Also, in the appendices, are additional instructional materials including “How to Read Scientific Articles” and “How to Read Epidemiologic Graphs, Tables, and Charts”.

Example One:

Cumulative Adult HIV Cases by Race/Ethnicity, Age at Diagnosis, Gender and Risk Cases Confirmed through December 2004											
New York State											
Males							Females				Total
	Risk						Risk				
	MSM	IDU	MSM/ IDU	HET	BLD	NRR/ NIR	IDU	HET	BLD	NRR/ NIR	
White											
13-19	42	3	3	2	2	14	5	40	0	21	132
20-24	301	21	7	8	5	36	29	71	1	44	523
25-29	646	51	20	40	3	135	53	113	2	69	1,132
30-49	3,277	374	91	163	15	1,001	241	408	8	324	5,902
50+	435	73	10	43	4	227	18	50	2	62	924
Black											
13-19	114	6	0	12	1	64	13	89	1	166	466
20-24	308	18	10	58	2	178	36	229	4	367	1,210
25-29	385	64	13	87	2	319	84	315	4	479	1,752
30-49	1,384	1,035	134	652	14	2,579	691	1,387	33	2,416	10,325
50+	154	359	26	143	7	742	114	245	7	408	2,205
Hispanic											
13-19	72	14	3	12	0	37	4	37	0	64	243
20-24	270	74	15	32	0	125	43	126	1	149	835
25-29	434	157	20	52	0	187	80	175	1	190	1,296
30-49	1,268	986	103	322	7	1,837	478	713	20	955	6,689
50+	125	197	6	72	6	401	61	119	3	201	1,191
Asian/PI											
13-19	3	0	0	0	0	1	1	2	0	1	8
20-24	16	1	0	2	0	3	0	3	0	5	30
25-29	42	0	2	2	0	11	0	5	0	17	79
30-49	97	10	2	13	0	64	4	14	0	34	238
50+	3	2	0	2	1	15	1	5	0	4	33
Native Am.											
13-19	0	0	0	0	0	1	0	0	0	1	2
20-24	0	0	0	0	0	0	0	0	0	4	4
25-29	5	0	1	0	0	3	1	2	0	2	14
30-49	6	2	1	1	0	12	3	6	0	6	37
50+	4	1	0	0	0	0	0	0	0	0	5
Total	9,391	3,448	467	1,718	69	7,992	1,960	4,154	87	5,989	35,275

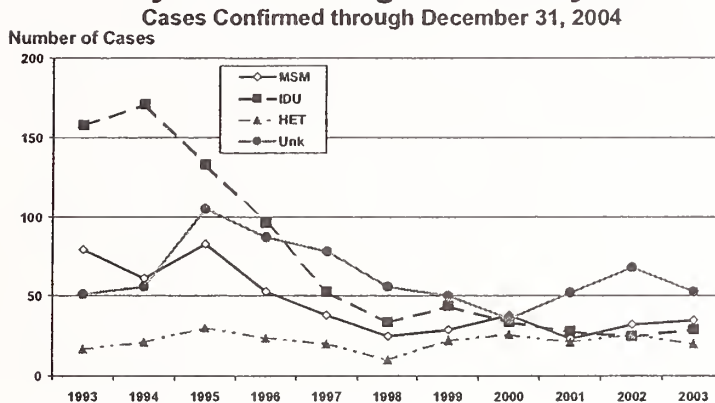
Interpretation

- A total of 35,275 cumulative adult HIV cases have been reported from June 1, 2000, through December 31, 2004
- 23,085 cases were among males (65%) and 12,190 among females (35%)
Male to female ratio is 1.9:1 (1.9 males for every 1 woman)
- Among males, the total cases attributed to MSM transmission is more than twice the total cases attributed to IDU
- Among males ages 50 years and older, MSM transmission is higher than IDU-related transmission among White, Asian and Pacific Islander, and Native American men while the reverse is evident among Black and Hispanic males
- Among women, the total cases attributed to IDU transmission is exceeded by the number of HIV cases attributed to heterosexual transmission
- Among women there are differences by race/ethnicity: Black women account for 58% or 7,088 cases, Hispanic women 28% or 3,420 cases, White women 13% or 1,561 cases, AP/I and Native American/Alaskan Native women each account for less than 1% or 96 and 25 cases, respectively
- The proportion of NRR/NIR cases is greater among women than among men
- Note: There may be some misclassification by race/ethnicity, particularly among people of color as not all race/ethnicity data is self-reported

Example Two:

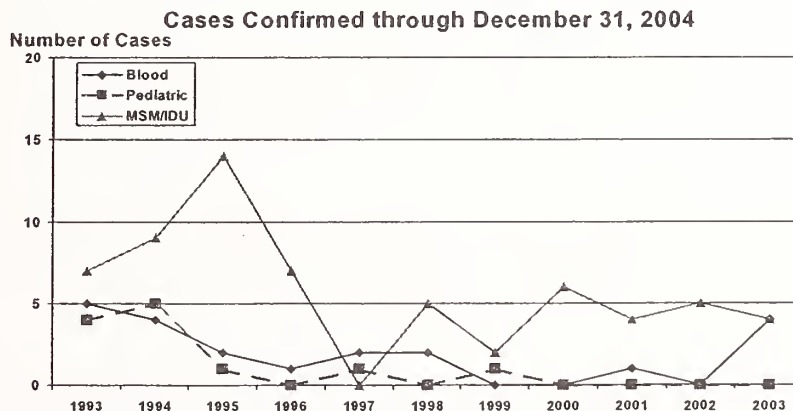
The following series of graphs display the annual number of AIDS cases diagnosed by transmission category for the period of 1993 through 2003. Each of the geographic sections of NYS (NYS, NYC, and NYS excluding NYC), each Ryan White Region, and each borough is displayed separately on two graphs. The only exception is the Binghamton RWR where all data is on one graph.

NYS AIDS Cases by Transmission Category, Year of Diagnosis and Ryan White Region: Albany #1



Graph #1 for each section, region, or borough will show trend data for the largest transmission categories; #2 will show the trend data for the smaller groups. The vertical scale, or axis, for graph #1 will always be larger than the vertical scale for #2. The scales will also vary from area to area. For example, the scale for the Bronx #1 (top value is 1400 cases) will be larger than the scale for Albany RWR #1 (top value 200).

NYS AIDS Cases by Transmission Category, Year of Diagnosis and Ryan White Region: Albany #2



Some trend lines (the lines on each graph representing a transmission category) are “choppier” than others. This is most obvious on the trend graphs that display low

numbers of cases. The “choppiness” is a side-effect of showing small numbers on a large graph in order to see the changes in number and the differences between lines.

To better understand this, look closely at Albany RWR #2. In 1998 there were 5 cases diagnosed among MSM/IDU (the trend line marked with triangles). In 1999, there were 2 and in 2000, there were 6 cases. On the Albany #2 graph this shows up as a dip and then a rise making the trend line “choppy” even though the difference from 1998 to 1999 is 3 cases and between 1999 and 2000 is 4 cases. For comparison, find the HET trend line on New York City #1. In 1998 to 2000 there was a similar pattern of up-down-up as there was in the Albany graph. In this case, however, the line is much smoother even though the change in the number of cases is greater: 1998 is 950 cases, 1999 is 900 cases, and 2000 is 975 cases. This line is much smoother as the value of the scale, or vertical axis, is larger. Both lines tell a similar story: a dip in 1999 between the relatively equal levels of 1998 and 2000; only the “dip” of the NYC #1 graph is meaningful.

Rates

HIV and AIDS case rates are displayed throughout this document. Rates are a common method of expressing the frequency of an occurrence during a set period of time. Miles per hour, for example, is used in everyday speech. Rates also allow for the comparison of numbers of cases among a group of locales of different population size.

In epidemiology, rates are defined as:

$$\text{Rate} = \frac{\text{Number of events in a given time period}}{\text{Average population during the time period}} \times 100^*$$

* The number shown here as “100” can be any multiple of 10 needed to convert the rate to a whole number; e.g. 21 per 100,000 rather than 2.1 per 10,000. It can also be expressed as 10ⁿ. Please see John M. Last (Editor), A Dictionary of Epidemiology, 4th Edition, Oxford University Press, 2000.

The rates in HIV and AIDS are usually a given number of cases that occurred during a specified time to a particular population or group as follows:

The HIV case rate in Metropolis County for 2003 is 47 per 10,000 population.

Time = 2003

Group = People living in Metropolis County during 2003

Event of interest = HIV diagnosis

Number of events = 47 per 10,000 population

This means that during 2003, 47 new cases of HIV infection were diagnosed for every 10,000 people living in Metropolis County.

The “per 10,000 population” is the portion that allows comparison. For example, if a state health department needed to compare four counties, the rates and the actual numbers of cases would both be important:

County	Mid-Year 2003 Population	Number of HIV Cases Diagnosed During 2003*	2003 HIV Case Rate per 10,000 Population*
Metropolis	25,000	118	47
Garrett	8,000	38	47
University	16,500	224	136
Watson	25,000	224	90

In absolute numbers, University and Watson Counties are equal but, by rate per 10,000 population, University County is experiencing a much more intense epidemic. Looking at Metropolis and Garrett Counties, their rates of HIV diagnosis are the same but represent a very different population size and actual number of cases.

Data Further Describing New York State



**NYS AIDS Cases by Transmission
Category, Year of Diagnosis, and
Geographic Area:
Ryan White Regions and
Boroughs of New York City**



**Cases Confirmed through December 31, 2004
By the Bureau of HIV/AIDS Epidemiology
NYSDOH**

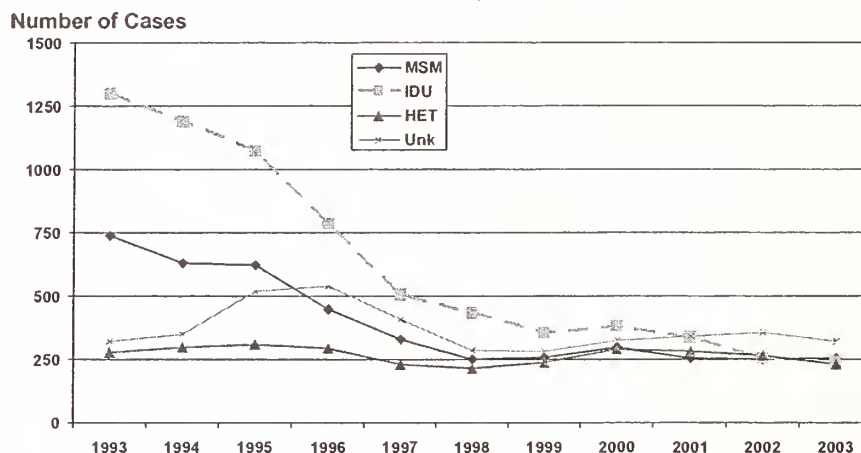
**Ryan White Regions
(Upstate NY or NYS excluding NYC)**



**Cases Confirmed through December 31, 2004
By the Bureau of HIV/AIDS Epidemiology
NYSDOH**

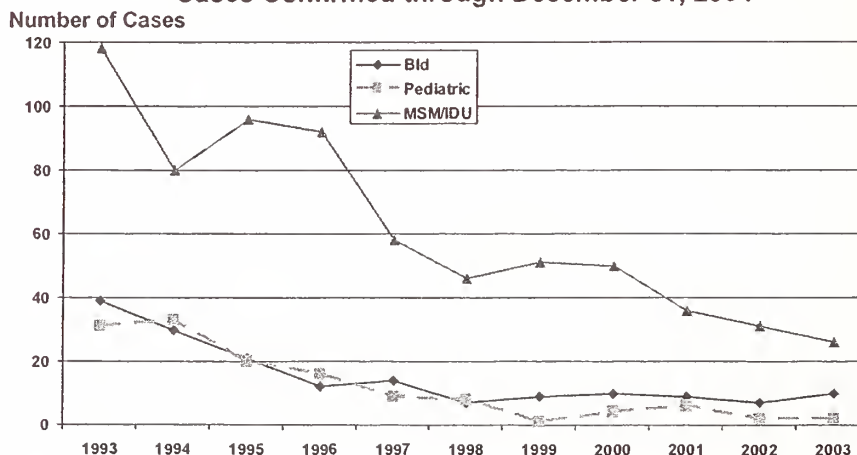
NYS AIDS Cases by Transmission Category and Year of Diagnosis **New York State, Excluding NYC #1**

Cases Confirmed through December 31, 2004



NYS AIDS Cases by Transmission Category and Year of Diagnosis **New York State, Excluding NYC #2**

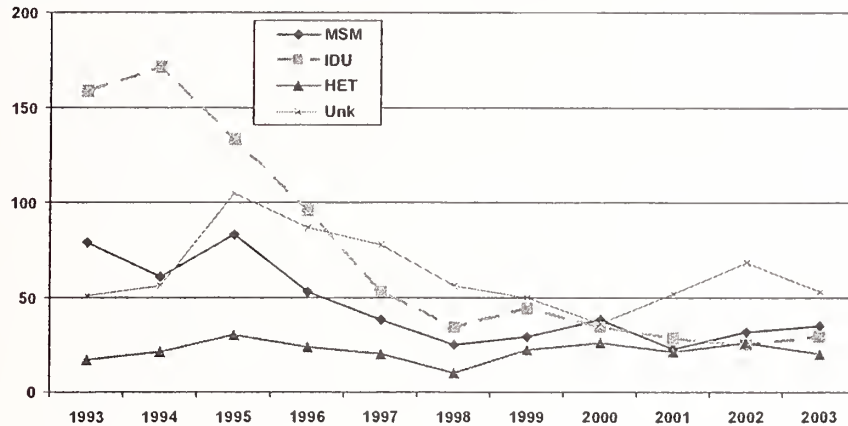
Cases Confirmed through December 31, 2004



NYS AIDS Cases by Transmission Category and Year of Diagnosis Albany Ryan White Region #1

Cases Confirmed through December 31, 2004

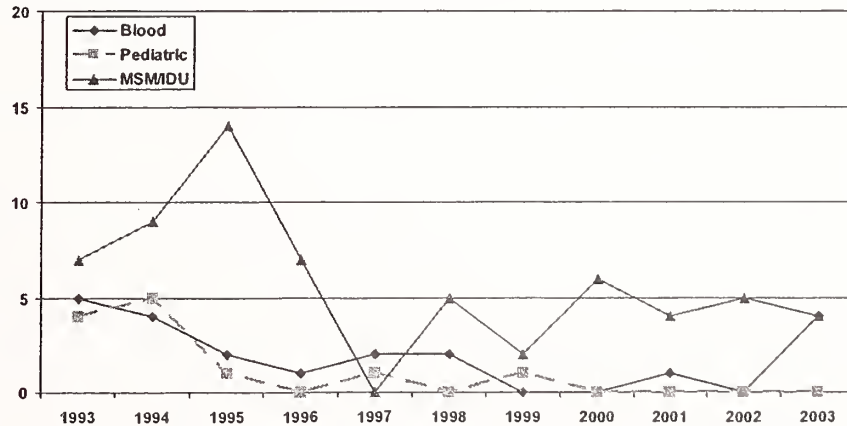
Number of Cases



NYS AIDS Cases by Transmission Category and Year of Diagnosis Albany Ryan White Region #2

Cases Confirmed through December 31, 2004

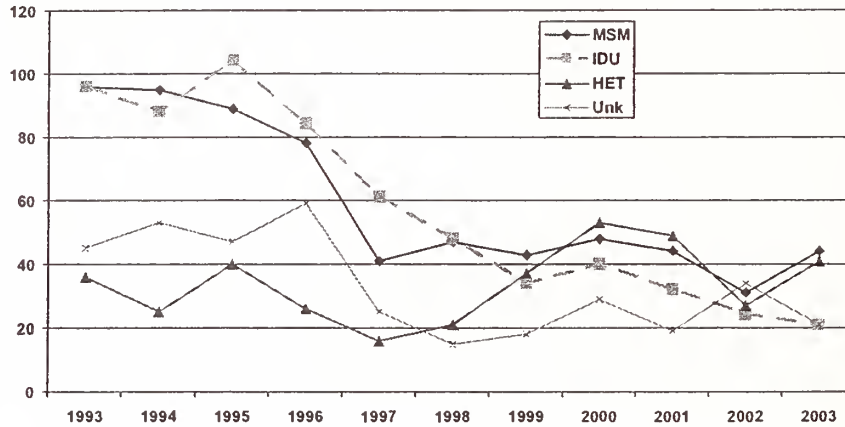
Number of Cases



NYS AIDS Cases by Transmission Category and Year of Diagnosis Buffalo Ryan White Region #1

Cases Confirmed through December 31, 2004

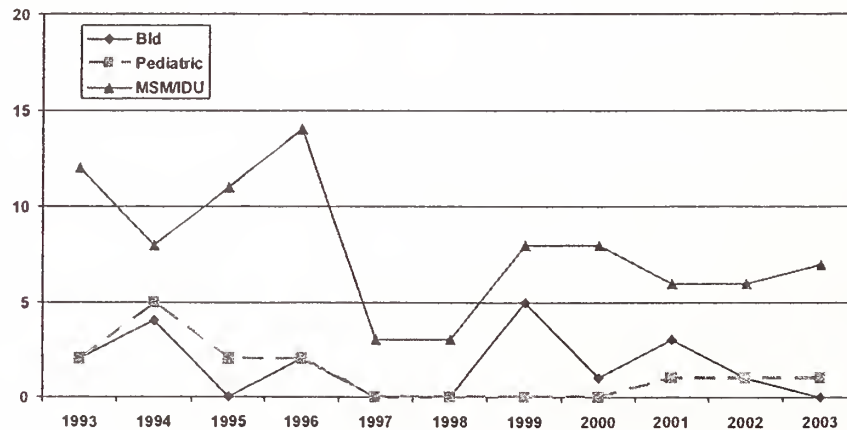
Number of Cases



NYS AIDS Cases by Transmission Category and Year of Diagnosis Buffalo Ryan White Region #2

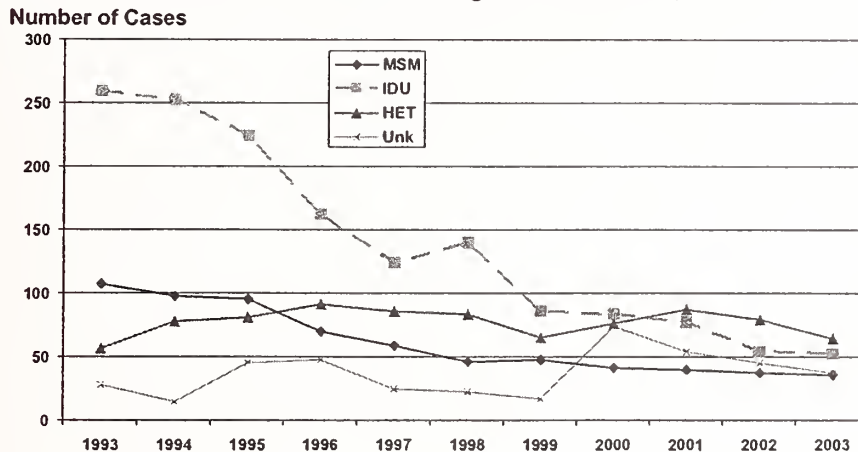
Cases Confirmed through December 31, 2004

Number of Cases



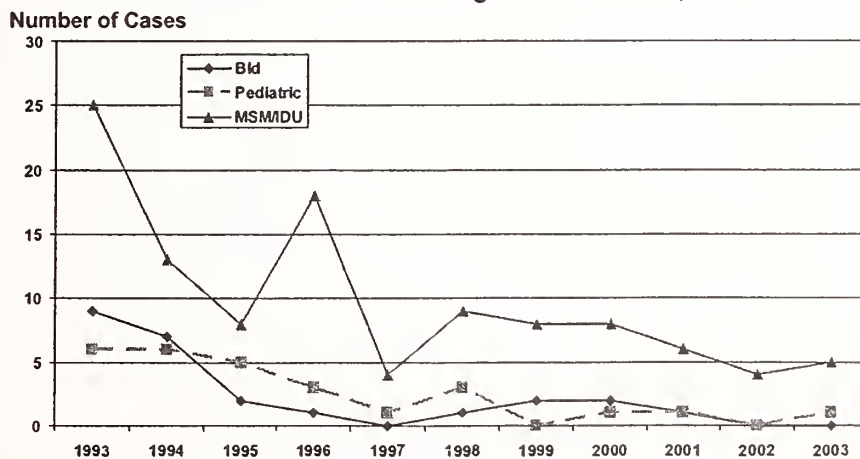
NYS AIDS Cases by Transmission Category and Year of Diagnosis Lower Hudson Ryan White Region #1

Cases Confirmed through December 31, 2004



NYS AIDS Cases by Transmission Category and Year of Diagnosis Lower Hudson Ryan White Region #2

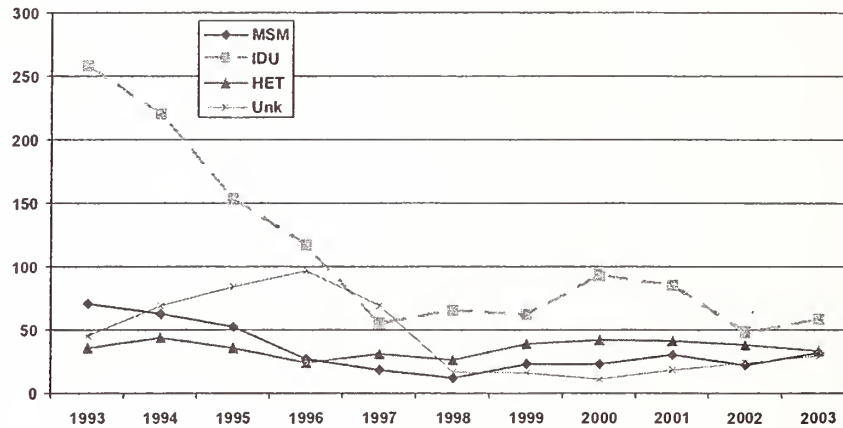
Cases Confirmed through December 31, 2004



NYS AIDS Cases by Transmission Category and Year of Diagnosis Mid Hudson Ryan White Region #1

Cases Confirmed through December 31, 2004

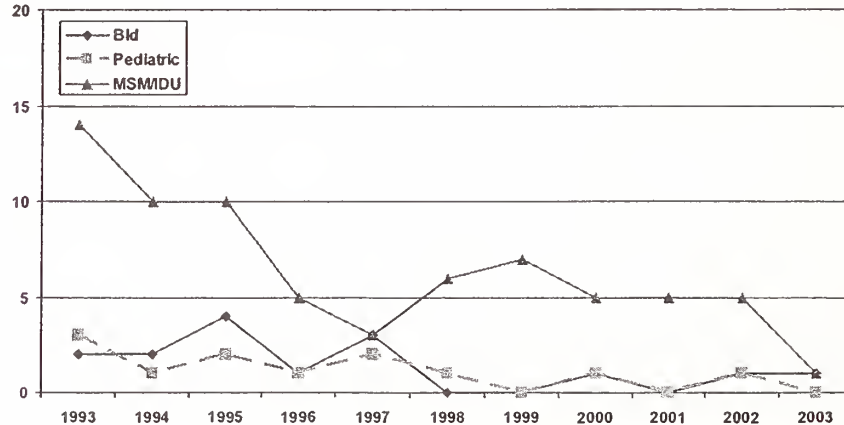
Number of Cases



NYS AIDS Cases by Transmission Category and Year of Diagnosis Mid Hudson Ryan White Region #2

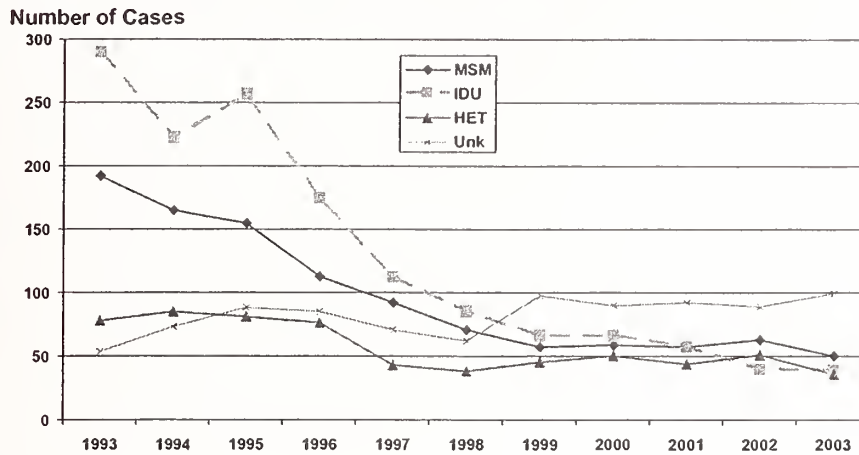
Cases Confirmed through December 31, 2004

Number of Cases



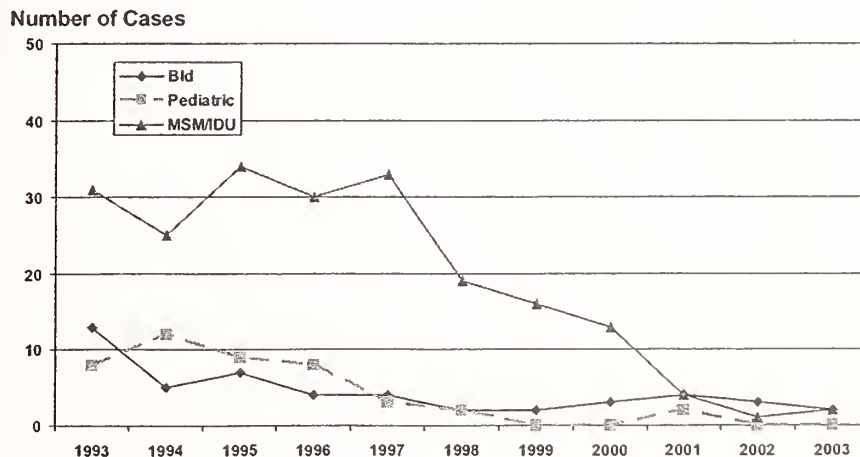
NYS AIDS Cases by Transmission Category and Year of Diagnosis Nassau/Suffolk Ryan White Region #1

Cases Confirmed through December 31, 2004



NYS AIDS Cases by Transmission Category and Year of Diagnosis Nassau/Suffolk Ryan White Region #2

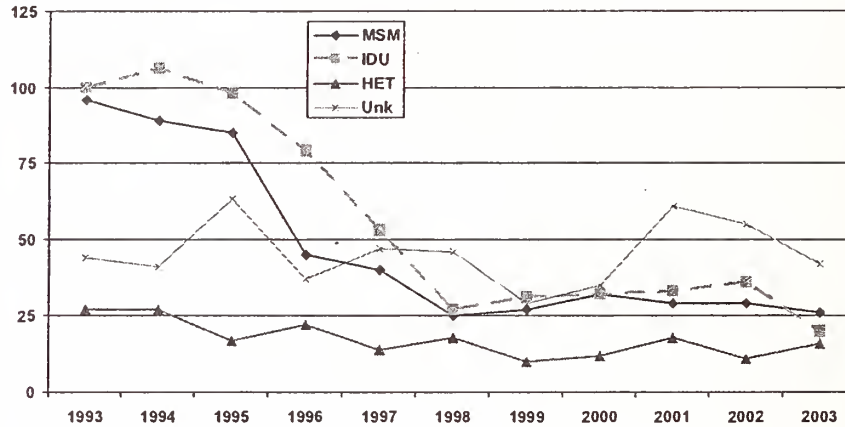
Cases Confirmed through December 31, 2004



NYS AIDS Cases by Transmission Category and Year of Diagnosis Rochester Ryan White Region #1

Cases Confirmed through December 31, 2004

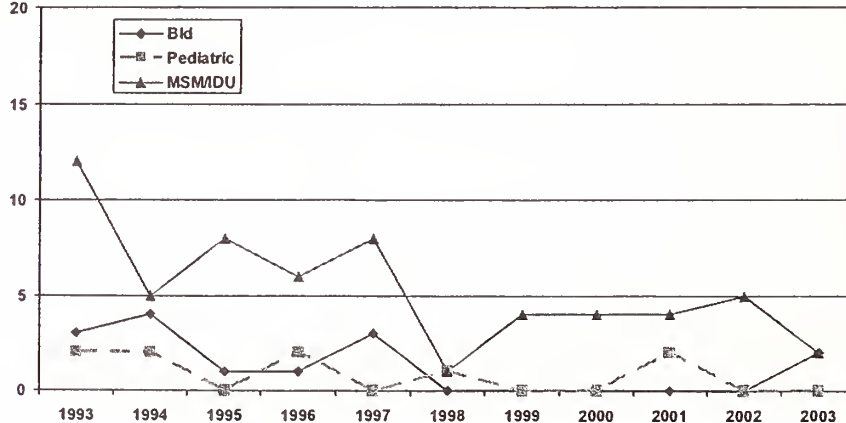
Number of Cases



NYS AIDS Cases by Transmission Category and Year of Diagnosis Rochester Ryan White Region #2

Cases Confirmed through December 31, 2004

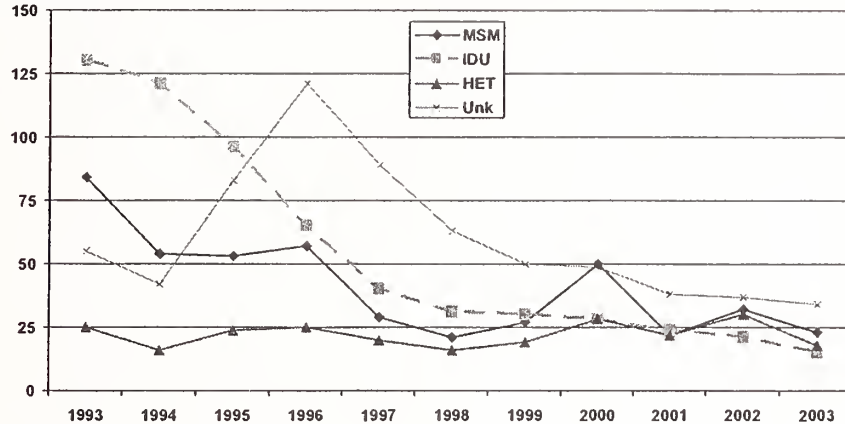
Number of Cases



NYS AIDS Cases by Transmission Category and Year of Diagnosis Syracuse Ryan White Region #1

Cases Confirmed through December 31, 2004

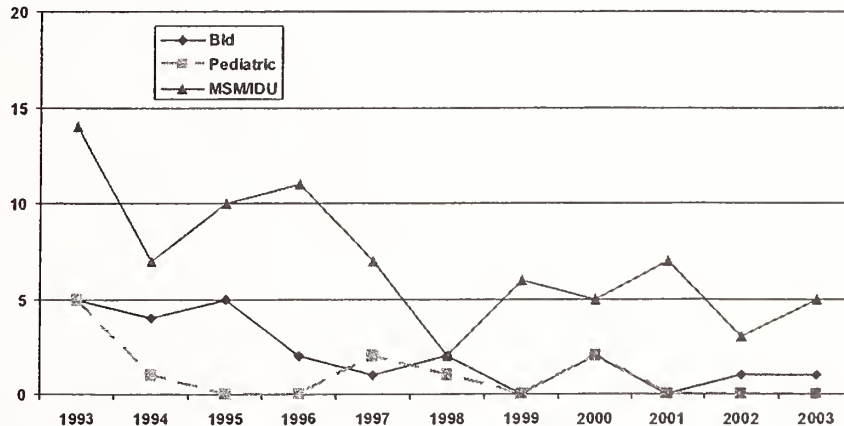
Number of Cases



NYS AIDS Cases by Transmission Category and Year of Diagnosis Syracuse Ryan White Region #2

Cases Confirmed through December 31, 2004

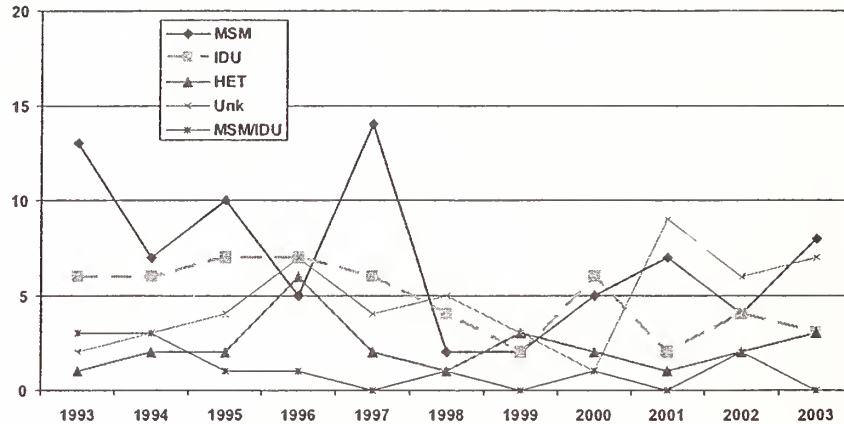
Number of Cases



NYS AIDS Cases by Transmission Category and Year of Diagnosis Binghamton Ryan White Region*

Cases Confirmed through December 31, 2004

Number of Cases



*Due to small cell numbers, data on other HIV exposure categories are not presented

Boroughs of New York City



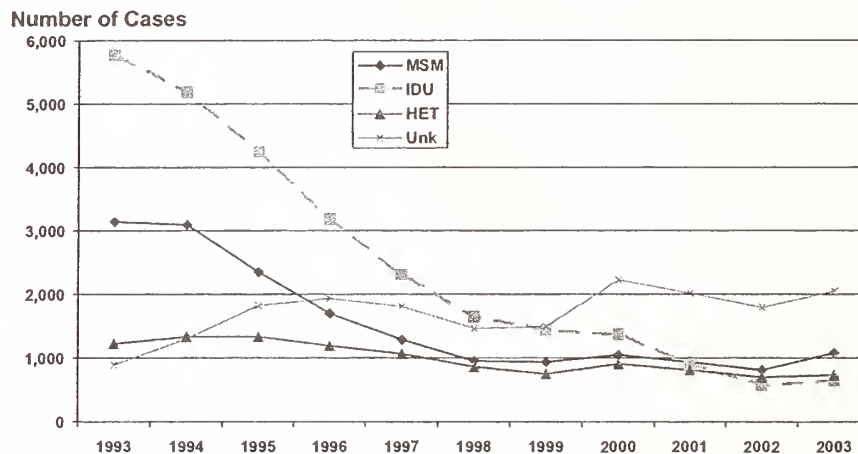
**Cases Confirmed through
December 31, 2004**

**By the Bureau of HIV/AIDS
Epidemiology**

NYSDOH

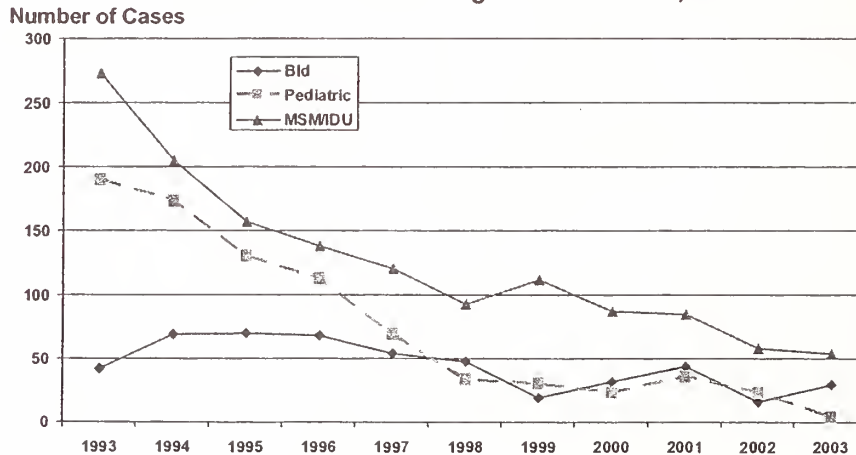
NYS AIDS Cases by Transmission Category and Year of Diagnosis New York City #1

Cases Confirmed through December 31, 2004



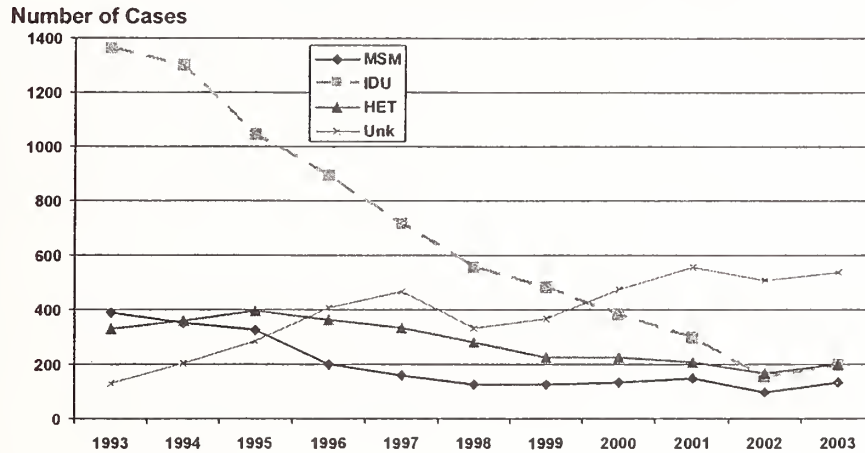
NYS AIDS Cases by Transmission Category and Year of Diagnosis New York City #2

Cases Confirmed through December 31, 2004



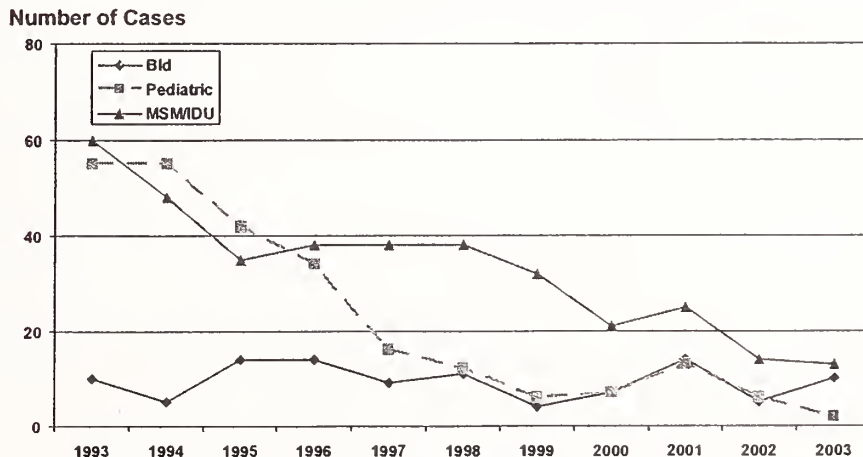
NYS AIDS Cases by Transmission Category and Year of Diagnosis New York City Borough: The Bronx #1

Cases Confirmed through December 31, 2004



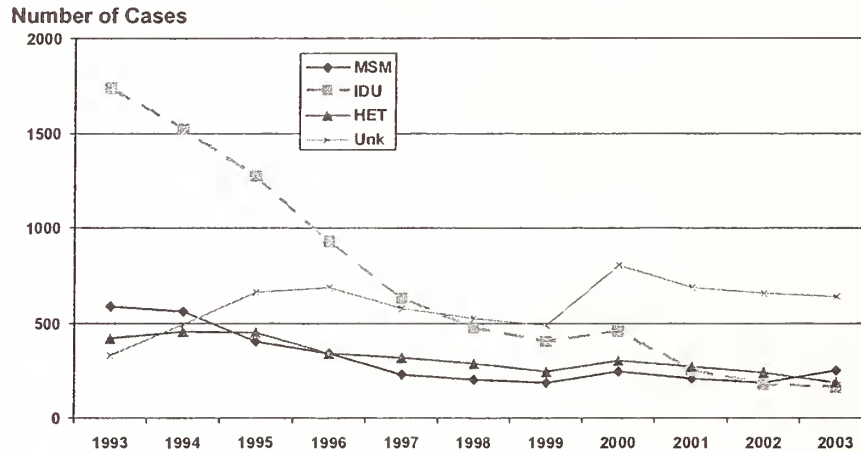
NYS AIDS Cases by Transmission Category and Year of Diagnosis New York City Borough: The Bronx #2

Cases Confirmed through December 31, 2004



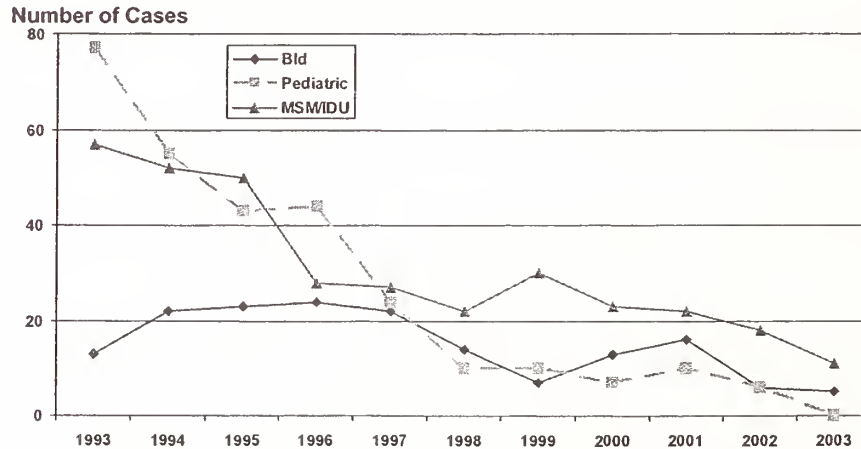
NYS AIDS Cases by Transmission Category and Year of Diagnosis **New York City Borough: Brooklyn #1**

Cases Confirmed through December 31, 2004



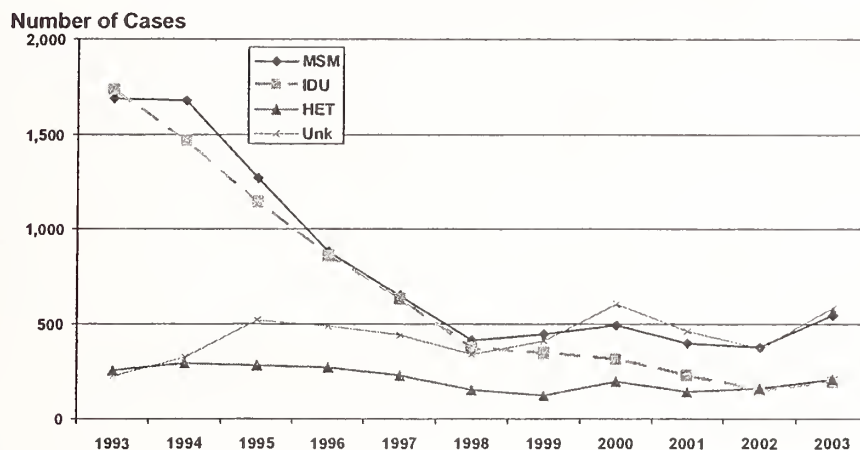
NYS AIDS Cases by Transmission Category and Year of Diagnosis **New York City Borough: Brooklyn #2**

Cases Confirmed through December 31, 2004



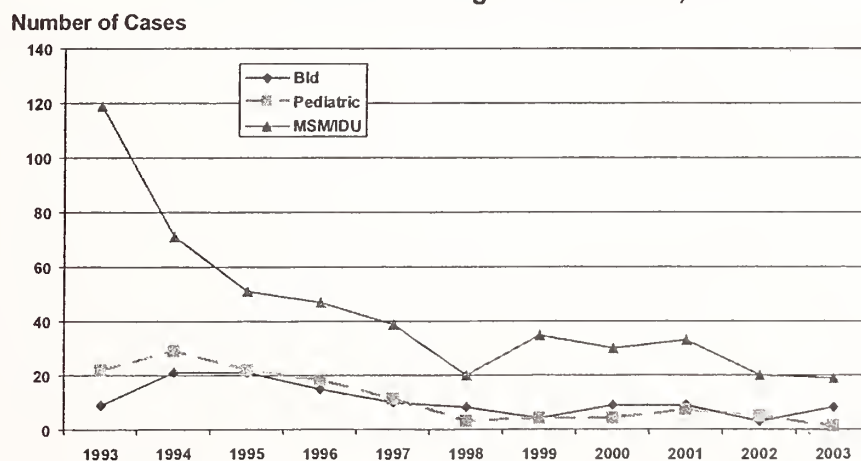
NYS AIDS Cases by Transmission Category and Year of Diagnosis **New York City Borough: Manhattan #1**

Cases Confirmed through December 31, 2004



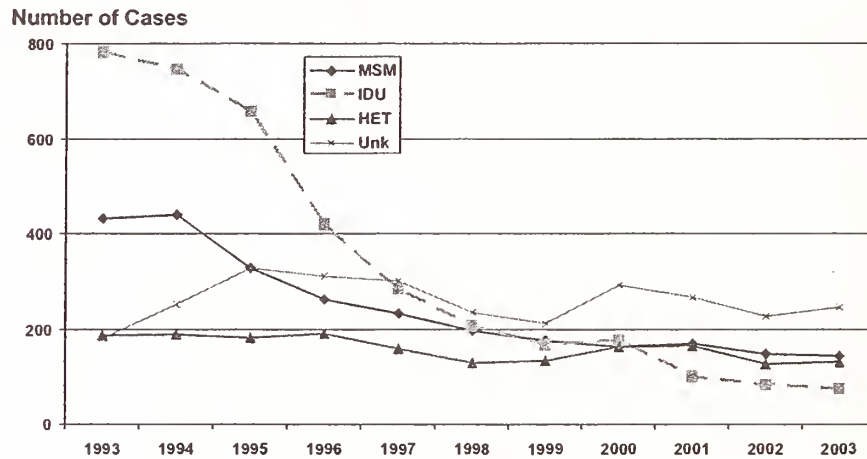
NYS AIDS Cases by Transmission Category and Year of Diagnosis **New York City Borough: Manhattan #2**

Cases Confirmed through December 31, 2004



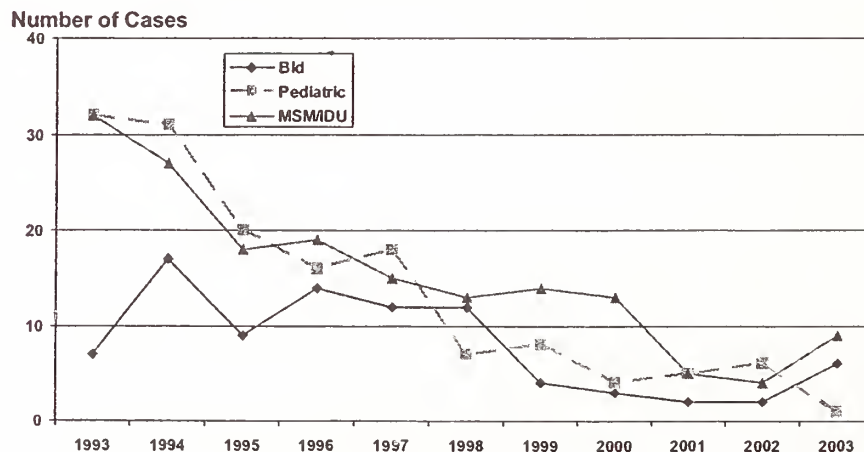
NYS AIDS Cases by Transmission Category and Year of Diagnosis **New York City Borough: Queens #1**

Cases Confirmed through December 31, 2004



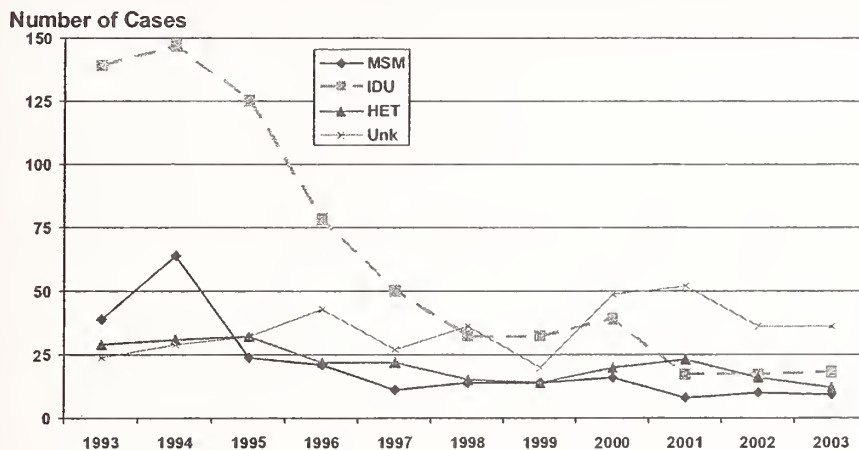
NYS AIDS Cases by Transmission Category and Year of Diagnosis **New York City Borough: Queens #2**

Cases Confirmed through December 31, 2004



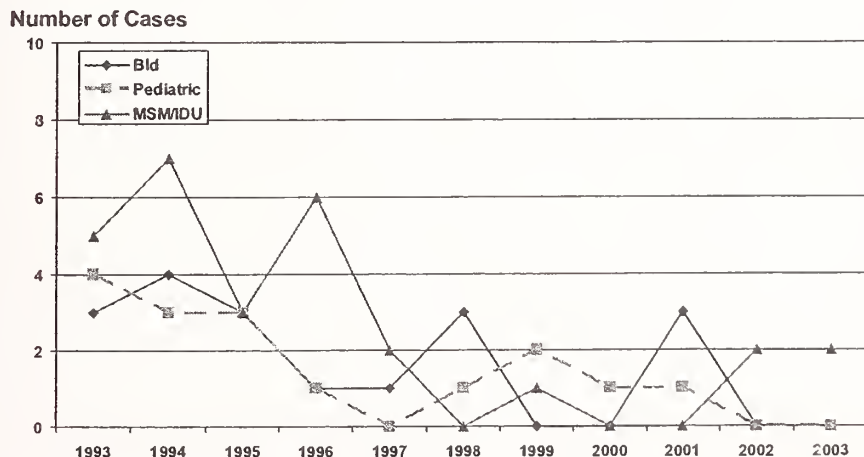
NYS AIDS Cases by Transmission Category and Year of Diagnosis New York City Borough: Staten Island #1

Cases Confirmed through December 31, 2004



NYS AIDS Cases by Transmission Category and Year of Diagnosis New York City Borough: Staten Island #2

Cases Confirmed through December 31, 2004



Cumulative Adult AIDS Cases in New York State
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Diagnosed through 2003 as Confirmed through December 2004

	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	14	0	3	1	29	21	3	13	2	12
20-24	329	81	25	8	42	33	72	110	6	24
25-29	2,258	518	183	32	57	183	345	293	11	113
30-49	17,857	5,970	1,096	448	167	1,812	2,188	1,208	53	620
50+	3,657	649	98	152	192	770	123	258	89	227
Black										
13-19	84	11	2	8	4	68	22	60	3	115
20-24	587	122	33	43	7	227	182	349	7	271
25-29	1,854	838	246	172	16	787	810	984	20	656
30-49	8,059	16,987	1,542	1,912	119	6,750	7,639	4,592	161	4,187
50+	1,595	3,368	201	578	73	2,178	776	795	67	871
Hispanic										
13-19	43	14	3	3	7	32	14	33	5	36
20-24	430	268	48	38	6	130	162	224	0	111
25-29	1,445	1,469	199	174	8	483	688	628	6	229
30-49	6,575	13,749	1,039	1,067	63	3,597	4,238	2,922	61	1,401
50+	1,181	1,770	94	280	33	1,113	288	575	31	380
Asian/Pi										
13-19	1	0	0	0	0	2	0	1	0	1
20-24	10	1	0	1	1	4	1	9	0	1
25-29	54	6	1	4	0	20	1	12	1	11
30-49	371	49	10	59	4	212	13	46	6	29
50+	66	14	1	13	6	59	2	7	5	19
Native Am.										
13-19	1	0	0	0	0	0	0	0	0	0
20-24	2	0	0	0	0	1	0	3	0	0
25-29	2	1	1	0	0	2	1	2	0	0
30-49	25	12	5	7	0	14	6	4	1	4
50+	7	3	0	0	0	3	0	0	1	0
Total	46,507	45,900	4,830	5,000	834	18,501	17,574	13,128	536	9,318

Cumulative Adult AIDS Cases in New York City
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Diagnosed through 2003 as Confirmed through December 2004

	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	9	0	2	0	13	11	3	1	0	7
20-24	197	49	15	6	11	23	53	3	0	14
25-29	1,593	320	104	15	17	116	134	7	0	58
30-49	13,809	3,940	639	261	57	1,247	648	24	0	399
50+	2,901	472	74	91	92	581	154	55	0	179
Black										
13-19	70	7	2	5	4	49	48	2	36	94
20-24	496	94	28	31	5	171	283	5	1	241
25-29	1,556	628	180	140	14	635	786	15	0	565
30-49	6,887	13,235	1,151	1,507	86	5,451	3,685	140	0	3,722
50+	1,418	2,780	154	475	62	1,923	647	56	0	781
Hispanic										
13-19	39	13	3	2	6	26	25	4	21	26
20-24	401	213	41	26	4	102	197	0	0	99
25-29	1,311	1,126	174	141	8	358	549	6	0	201
30-49	6,109	11,496	888	893	53	2,798	2,612	53	0	1,267
50+	1,114	1,580	78	254	29	1,009	533	30	0	364
Asian/Pi										
13-19	1	0	0	0	0	2	1	0	0	1
20-24	9	1	0	1	1	4	4	0	0	1
25-29	51	5	1	4	0	18	10	1	0	9
30-49	352	47	8	53	3	200	42	5	0	28
50+	61	13	1	13	6	51	6	5	0	17
Native Am.										
13-19	0	0	0	0	0	0	0	0	0	0
20-24	2	0	0	0	0	0	0	0	0	0
25-29	0	1	1	0	0	2	2	0	0	0
30-49	14	3	2	4	0	7	2	0	0	1
50+	5	3	0	0	0	3	0	1	0	0
Total	38,405	36,026	3,546	3,922	471	14,787	10,424	413	58	8,074

Cumulative Adult AIDS Cases in New York State Excluding NYC

by Race/Ethnicity, Age at Diagnosis, Gender and Risk

Cases Diagnosed through 2003 as Confirmed through December 2004

	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	5	0	1	1	16	10	2	10	1	5
20-24	132	32	10	2	31	10	26	57	3	10
25-29	665	198	79	17	40	67	109	159	4	55
30-49	4,048	2,030	457	187	110	565	704	560	29	221
50+	756	177	24	61	100	189	29	104	34	48
Black										
13-19	14	4	0	3	0	19	4	12	1	21
20-24	91	28	5	12	2	56	29	66	2	30
25-29	298	210	66	32	2	152	136	198	5	91
30-49	1,172	3,752	391	405	33	1,299	1,239	907	21	465
50+	177	588	47	103	11	255	82	148	11	90
Hispanic										
13-19	4	1	0	UPS	1	6	0	8	1	10
20-24	29	55	7	12	2	28	14	27	0	12
25-29	134	343	25	33	0	125	69	79	0	28
30-49	466	2,253	151	174	10	799	336	310	8	134
50+	67	190	16	26	4	104	14	42	1	16
Asian/PI										
13-19	0	0	0	0	0	0	0	0	0	0
20-24	1	0	0	0	0	0	0	5	0	0
25-29	3	1	0	0	0	2	0	2	0	2
30-49	19	2	2	6	1	12	1	4	1	1
50+	5	1	0	0	0	8	0	1	0	2
Native Am										
13-19	1	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	1	0	3	0	0
25-29	2	0	0	0	0	0	1	0	0	0
30-49	11	9	3	3	0	7	4	2	1	3
50+	2	0	0	0	0	0	0	0	0	0
Total	8,102	9,874	1,284	1,077	363	3,714	2,799	2,704	123	1,244

Cumulative Adult HIV Cases in New York State
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Diagnosed through 2003 as Confirmed through December 2004

	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	42	3	3	2	2	14	5	40	0	21
20-24	301	21	7	8	5	36	29	71	1	44
25-29	646	51	20	40	3	135	53	113	2	69
30-49	3,277	374	91	163	15	1,001	241	408	8	324
50+	435	73	10	43	4	227	18	50	2	62
Black										
13-19	114	6	0	12	1	64	13	89	1	166
20-24	308	18	10	58	2	178	36	229	4	367
25-29	385	64	13	87	2	319	84	315	4	479
30-49	1,384	1,035	134	652	14	2,579	691	1,387	33	2,416
50+	154	359	26	143	7	742	114	245	7	408
Hispanic										
13-19	72	14	3	12	0	37	4	37	0	64
20-24	270	74	15	32	0	125	43	126	1	149
25-29	434	157	20	52	0	187	80	175	1	190
30-49	1,268	986	103	322	7	1,837	478	713	20	955
50+	125	197	6	72	6	401	61	119	3	201
Asian/Pi										
13-19	3	0	0	0	0	1	1	2	0	1
20-24	16	1	0	2	0	3	0	3	0	5
25-29	42	0	2	2	0	11	0	5	0	17
30-49	97	10	2	13	0	64	4	14	0	34
50+	3	2	0	2	1	15	1	5	0	4
Native Am										
13-19	0	0	0	0	0	1	0	0	0	1
20-24	0	0	0	0	0	0	0	0	0	4
25-29	5	0	1	0	0	3	1	2	0	2
30-49	6	2	1	1	0	12	3	6	0	6
50+	4	1	0	0	0	0	0	0	0	0
Total	9,391	3,448	467	1,718	69	7,992	1,960	4,154	87	5,989

Cumulative Adult HIV Cases in New York City
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Diagnosed through 2003 as Confirmed through December 2004

	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	22	0	0	1	2	8	2	8	0	6
20-24	207	7	4	2	2	28	13	21	0	22
25-29	490	26	6	22	1	107	15	42	2	37
30-49	2,526	198	52	103	7	765	113	185	4	208
50+	329	45	7	29	1	170	13	29	1	39
Black										
13-19	89	2	0	8	1	48	6	59	1	133
20-24	246	4	5	38	1	145	18	149	4	330
25-29	318	35	7	58	2	228	50	232	3	424
30-49	1,144	572	83	491	10	1,872	430	1,005	28	2,118
50+	130	269	23	114	6	572	79	192	6	355
Hispanic										
13-19	63	7	1	10	0	33	2	29	0	59
20-24	238	42	14	27	0	101	27	95	1	137
25-29	387	79	15	36	0	159	51	136	1	168
30-49	1,167	646	84	264	5	1,254	362	582	19	815
50+	116	152	6	63	3	277	48	102	3	180
Asian/Pi										
13-19	2	0	0	0	0	0	1	2	0	1
20-24	15	1	0	2	0	3	0	3	0	4
25-29	40	0	2	1	0	9	0	4	0	16
30-49	94	9	1	12	0	57	2	14	0	29
50+	3	2	0	2	0	13	1	5	0	4
Native Am.										
13-19	0	0	0	0	0	1	0	0	0	1
20-24	0	0	0	0	0	0	0	0	0	2
25-29	3	0	1	0	0	1	0	0	0	0
30-49	4	1	0	1	0	5	1	4	0	5
50+	2	0	0	0	0	0	0	0	0	0
Total	7,635	2,097	311	1,284	41	5,856	1,234	2,898	73	5,093

Cumulative Adult HIV Cases in New York State excluding New York City
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Diagnosed through 2003 as Confirmed through December 2004

Males							Females				
	Risk						Risk				
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR	
White											
13-19	20	3	3	1	0	6	3	32	0	15	
20-24	94	14	3	6	3	8	16	50	1	22	
25-29	156	25	14	18	2	28	38	71	0	32	
30-49	751	176	39	60	8	236	128	223	4	116	
50+	106	28	3	14	3	57	5	21	1	23	
Black											
13-19	25	4	0	4	0	16	7	30	0	33	
20-24	62	14	5	20	1	33	18	80	0	37	
25-29	67	29	6	29	0	91	34	83	1	55	
30-49	240	463	51	161	4	707	261	382	5	298	
50+	24	90	3	29	1	170	35	53	1	53	
Hispanic											
13-19	9	7	2	2	0	4	2	8	0	5	
20-24	32	32	1	5	0	24	16	31	0	12	
25-29	47	78	5	16	0	28	29	39	0	22	
30-49	101	340	19	58	2	583	116	131	1	140	
50+	9	45	0	9	3	124	13	17	0	21	
Asian/Pi											
13-19	1	0	0	0	0	1	0	0	0	0	
20-24	1	0	0	0	0	0	0	0	0	1	
25-29	2	0	0	1	0	2	0	1	0	1	
30-49	3	1	1	1	0	7	2	0	0	5	
50+	0	0	0	0	1	2	0	0	0	0	
Native Am.											
13-19	0	0	0	0	0	0	0	0	0	0	
20-24	0	0	0	0	0	0	0	0	0	2	
25-29	2	0	0	0	0	2	1	2	0	2	
30-49	2	1	1	0	0	7	2	2	0	1	
50+	2	1	0	0	0	0	0	0	0	0	
Total	1,756	1,351	156	434	28	2,136	726	1,256	14	896	

Adult AIDS Cases Diagnosed in 2002-2003
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Confirmed through December 2004
New York State

	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	1	0	0	0	0	5	0	1	0	2
20-24	14	0	0	1	0	6	1	5	0	2
25-29	51	2	3	3	0	19	3	11	1	7
30-49	737	104	34	62	2	242	56	88	2	111
50+	192	46	5	26	4	101	11	24	2	33
Black										
13-19	16	0	0	1	1	14	0	6	0	17
20-24	54	5	0	4	1	34	4	24	0	42
25-29	90	11	2	16	0	62	7	73	3	83
30-49	503	316	54	283	9	1031	215	501	12	840
50+	86	215	17	89	2	388	69	120	4	208
Hispanic										
13-19	4	0	0	2	0	8	0	4	0	7
20-24	40	6	0	7	0	18	3	15	0	16
25-29	73	10	2	17	1	52	13	21	0	46
30-49	424	337	41	168	4	476	132	219	4	259
50+	63	96	11	44	2	184	21	59	6	84
Asian/Pi										
13-19	0	0	0	0	0	0	0	1	0	0
20-24	2	0	0	0	0	1	0	2	0	0
25-29	2	0	0	0	0	2	0	3	0	1
30-49	31	2	0	15	0	29	3	6	0	5
50+	5	0	0	2	1	10	1	1	1	4
Native Am.										
13-19	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	1	0	0
25-29	1	0	0	0	0	0	0	0	0	0
30-49	6	0	0	1	0	4	1	1	0	0
50+	2	1	0	0	0	1	0	0	0	1
Total	2,397	1,151	169	741	27	2,687	540	1,186	35	1,768

Adult AIDS Cases Diagnosed in 2002-2003
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Confirmed through December 2004
New York City

	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	0	0	0	0	0	1	0	1	0	1
20-24	6	0	0	1	0	4	0	1	0	1
25-29	39	1	1	0	0	13	1	2	1	4
30-49	519	57	20	43	0	161	26	43	1	73
50+	143	32	3	14	2	79	9	19	2	23
Black										
13-19	12	0	0	0	1	11	0	4	0	15
20-24	44	3	0	4	1	27	3	20	0	39
25-29	73	6	1	12	0	47	5	60	1	77
30-49	420	197	30	211	5	869	151	362	11	748
50+	68	157	11	66	2	336	55	89	2	186
Hispanic										
13-19	4	0	0	2	0	8	0	3	0	6
20-24	39	5	0	6	0	17	3	14	0	15
25-29	64	5	2	12	1	45	11	16	0	41
30-49	366	268	34	134	3	403	110	183	2	235
50+	56	76	10	38	2	163	21	50	6	82
Asian/Pi										
13-19	0	0	0	0	0	0	0	1	0	0
20-24	2	0	0	0	0	1	0	2	0	0
25-29	2	0	0	0	0	1	0	3	0	1
30-49	31	2	0	14	0	26	3	5	0	5
50+	5	0	0	2	1	10	1	1	1	3
Native Am.										
13-19	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	0	0	0
25-29	0	0	0	0	0	0	0	0	0	0
30-49	4	0	0	1	0	1	0	1	0	1
50+	1	1	0	0	0	1	0	0	0	0
Total	1,898	810	112	560	18	2,224	399	880	27	1,556

Adult AIDS Cases Diagnosed in 2002-2003
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Confirmed through December 2004
New York State Excluding NYC

Males							Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	1	0	0	0	0	4	0	0	0	1
20-24	8	0	0	0	0	2	1	4	0	1
25-29	12	1	2	3	0	6	2	9	0	3
30-49	218	47	14	19	2	81	30	45	1	38
50+	49	14	2	12	2	22	2	5	0	10
Black										
13-19	4	0	0	1	0	3	0	2	0	2
20-24	10	2	0	0	0	7	1	4	0	3
25-29	17	5	1	4	0	15	2	13	2	6
30-49	83	119	24	72	4	162	64	139	1	92
50+	18	58	6	23	0	52	14	31	2	22
Hispanic										
13-19	0	0	0	0	0	0	0	1	0	1
20-24	1	1	0	1	0	1	0	1	0	1
25-29	9	5	0	5	0	7	2	5	0	5
30-49	58	69	7	34	1	73	22	36	2	24
50+	7	20	1	6	0	21	0	9	0	2
Asian/Pi										
13-19	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	0	0	0
25-29	0	0	0	0	0	1	0	0	0	0
30-49	0	0	0	1	0	3	0	1	0	0
50+	0	0	0	0	0	0	0	0	0	1
Native Am.										
13-19	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	1	0	0
25-29	1	0	0	0	0	0	0	0	0	0
30-49	2	0	0	0	0	3	1	0	0	0
50+	1	0	0	0	0	0	0	0	0	0
Total	499	341	57	181	9	463	141	306	8	212

Adult HIV Cases Diagnosed in 2002-2003
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Confirmed through December 2004
New York State

Males							Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	9	0	0	0	0	5	0	1	0	6
20-24	51	2	0	1	1	10	5	7	0	10
25-29	107	3	2	5	0	27	4	11	1	15
30-49	559	48	13	28	0	132	38	59	0	55
50+	66	16	2	10	2	29	2	11	0	20
Black										
13-19	53	1	0	2	0	24	3	12	0	58
20-24	94	2	0	18	0	56	2	43	1	124
25-29	97	3	2	9	0	91	4	64	1	138
30-49	361	138	16	166	2	628	92	295	5	597
50+	53	79	7	34	2	177	28	57	0	109
Hispanic										
13-19	28	2	0	2	0	9	1	4	0	15
20-24	75	11	3	6	0	40	2	31	0	39
25-29	114	10	7	10	0	50	3	30	1	34
30-49	314	124	26	81	0	277	64	131	3	183
50+	29	37	1	16	1	65	14	28	1	46
Asian/Pi										
13-19	0	0	0	0	0	0	0	0	0	1
20-24	2	1	0	1	0	1	0	0	0	2
25-29	15	0	0	1	0	1	0	0	0	4
30-49	30	1	0	7	0	21	1	1	0	12
50+	0	0	0	1	0	4	0	1	0	3
Native Am.										
13-19	0	0	0	0	0	0	0	0	0	1
20-24	0	0	0	0	0	0	0	1	0	3
25-29	1	0	0	0	0	1	0	1	0	1
30-49	3	0	0	1	0	2	1	0	0	2
50+	2	0	0	0	0	0	0	0	0	0
Total	2,063	478	79	399	8	1,650	264	788	13	1,478

Adult HIV Cases Diagnosed in 2002-2003
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Confirmed through December 2004
New York City

	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	5	0	0	0	0	4	0	0	0	3
20-24	41	2	0	0	1	8	4	4	0	7
25-29	93	2	2	4	0	19	1	5	1	11
30-49	449	29	9	24	0	99	19	32	0	33
50+	49	12	2	9	1	26	2	5	0	12
Black										
13-19	47	1	0	2	0	18	1	9	0	49
20-24	75	2	0	13	0	50	1	33	1	115
25-29	90	3	2	9	0	75	2	55	1	125
30-49	319	93	13	129	2	549	67	225	3	551
50+	42	56	7	30	2	159	21	45	0	96
Hispanic										
13-19	23	2	0	2	0	8	1	1	0	14
20-24	68	11	3	6	0	34	2	26	0	37
25-29	103	9	7	9	0	45	2	22	1	31
30-49	287	112	19	65	0	257	55	118	3	162
50+	28	31	1	15	0	63	13	23	1	44
Asian/PI										
13-19	0	0	0	0	0	0	0	0	0	1
20-24	2	1	0	1	0	1	0	0	0	2
25-29	15	0	0	1	0	1	0	0	0	4
30-49	28	1	0	6	0	21	1	1	0	10
50+	0	0	0	1	0	3	0	1	0	2
Native Am.										
13-19	0	0	0	0	0	0	0	0	0	1
20-24	0	0	0	0	0	0	0	0	0	2
25-29	1	0	0	0	0	0	0	0	0	0
30-49	2	0	0	1	0	1	1	0	0	1
50+	1	0	0	0	0	0	0	0	0	0
Total	1,768	367	65	327	6	1,441	193	605	11	1,313

Adult HIV Cases Diagnosed in 2002-2003
by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Confirmed through December 2004
New York State Excluding NYC

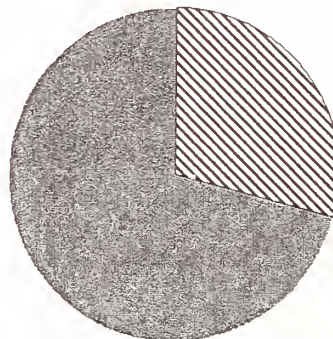
	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	4	0	0	0	0	1	0	1	0	3
20-24	10	0	0	1	0	2	1	3	0	3
25-29	14	1	0	1	0	8	3	6	0	4
30-49	110	19	4	4	0	33	19	27	0	22
50+	17	4	0	1	1	3	0	6	0	8
Black										
13-19	6	0	0	0	0	6	2	3	0	9
20-24	19	0	0	5	0	6	1	10	0	9
25-29	7	0	0	0	0	16	2	9	0	13
30-49	42	45	3	37	0	79	25	70	2	46
50+	11	23	0	4	0	18	7	12	0	13
Hispanic										
13-19	5	0	0	0	0	1	0	3	0	1
20-24	7	0	0	0	0	6	0	5	0	2
25-29	11	1	0	1	0	5	1	8	0	3
30-49	27	12	7	16	0	20	9	13	0	21
50+	1	6	0	1	1	2	1	5	0	2
Asian/Pi										
13-19	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	0	0	0
25-29	0	0	0	0	0	0	0	0	0	0
30-49	2	0	0	1	0	0	0	0	0	2
50+	0	0	0	0	0	1	0	0	0	1
Native Am.										
13-19	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	1	0	1
25-29	0	0	0	0	0	1	0	1	0	1
30-49	1	0	0	0	0	1	0	0	0	1
50+	1	0	0	0	0	0	0	0	0	0
Total	295	111	14	72	2	209	71	183	2	165

**AIDS Cases Among
Adults/Adolescents Ages 13-24
Diagnosed 2000-2003 by
Age at Diagnosis and
Transmission Category**



Data as Reported through 2004 by the
Bureau of HIV/AIDS Epidemiology
NYSDOH

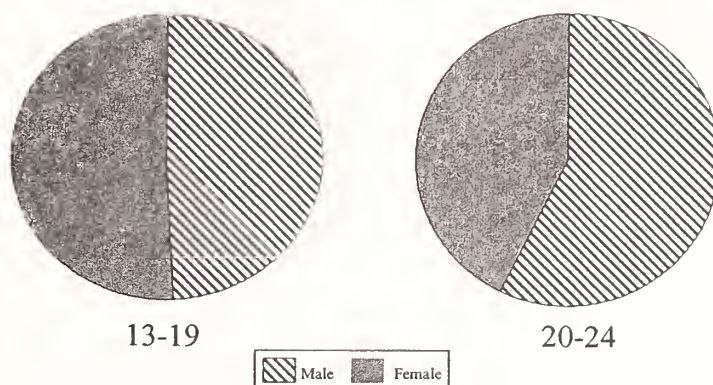
**AIDS Cases Among
Adults/Adolescents Ages 13-24
Diagnosed 2000-2003* by
Age at Diagnosis**



▨ 13-19 ■ 20-24

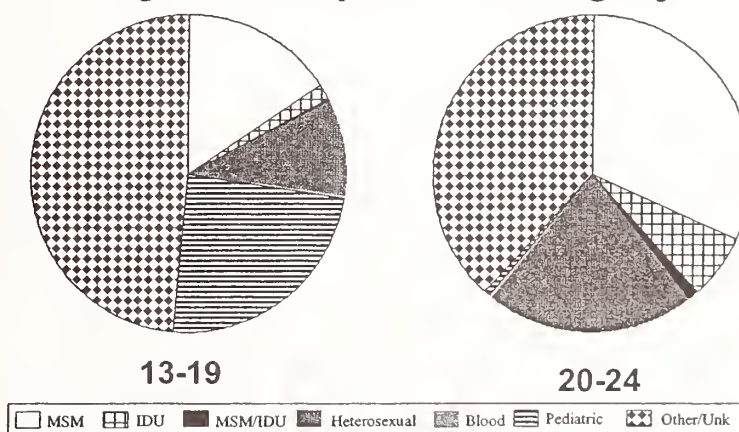
* Cases confirmed through December 2004

AIDS Cases Among Adults/Adolescents Ages 13-24 Diagnosed 2000-2003* by Age at Diagnosis and Gender



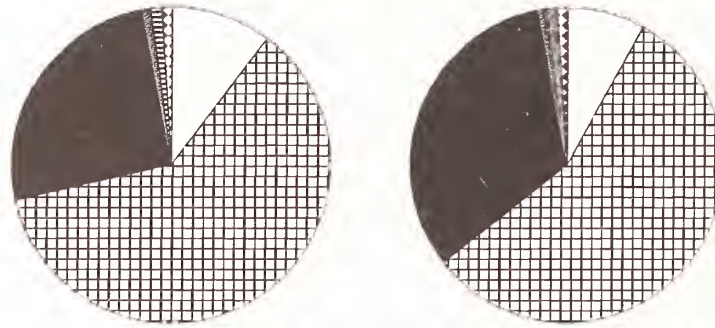
* Cases confirmed through December 2004

AIDS Cases Among Adults/Adolescents Ages 13-24 Diagnosed 2000-2003* by Age and Exposure Category



* Cases confirmed through December 2004

AIDS Cases Among Adults/Adolescents Ages 13-24 Diagnosed 2000-2003* by Age and Race/Ethnicity



Ages 13-19

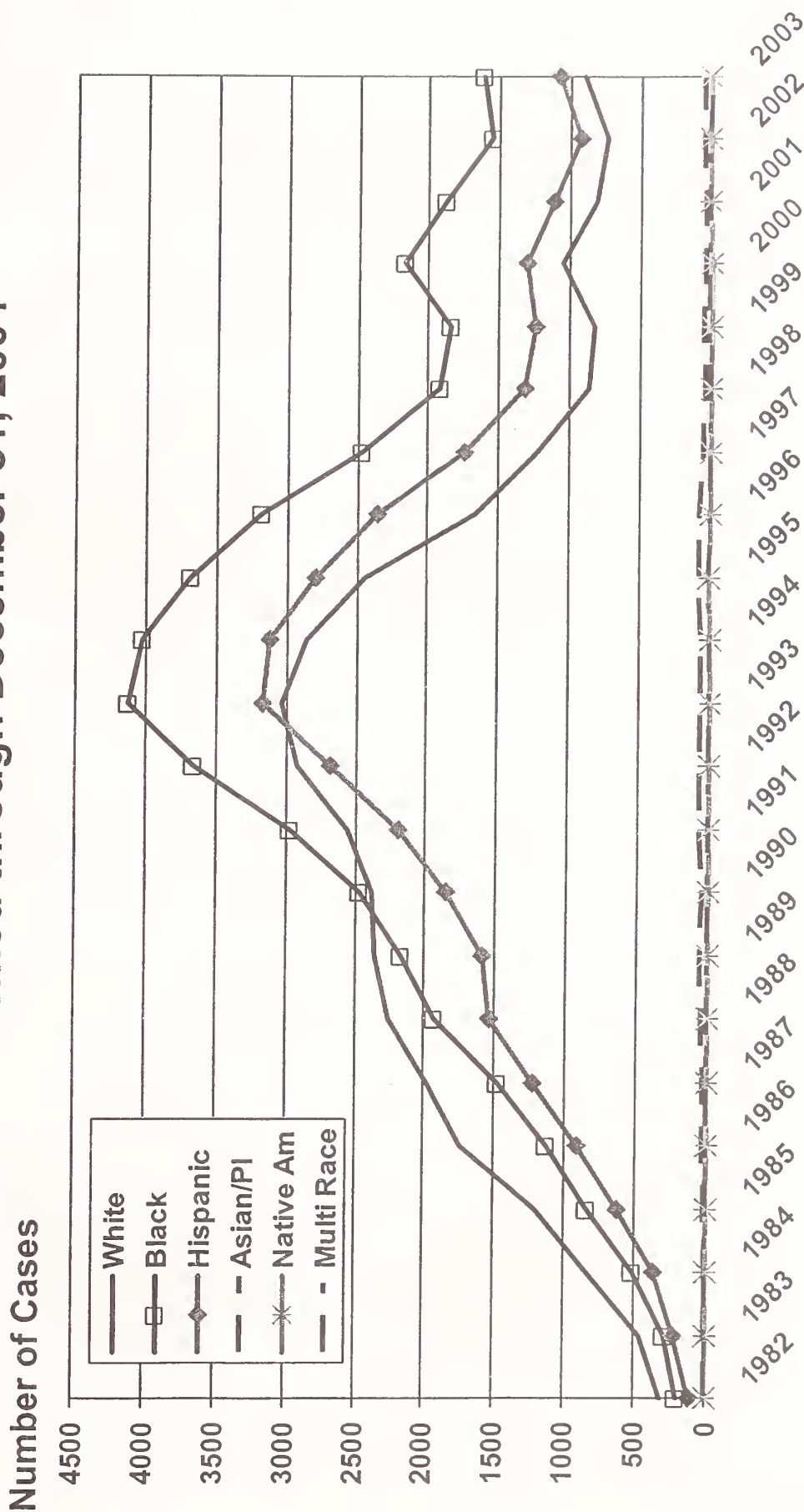
20-24

White
 Black
 Hispanic
 Asian/Pi
 Native Amer
 Multi Race
 Other/Unk

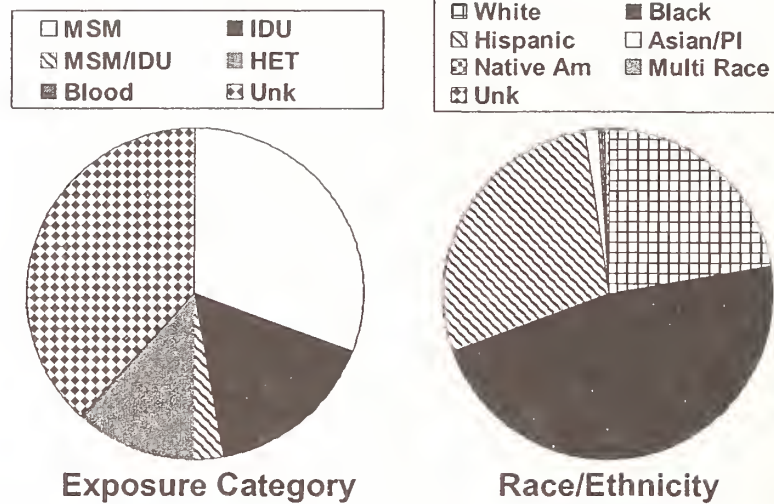
* Cases confirmed through December 2004

Cumulative NYS AIDS Cases Among Adult Males Ages 25+ by Year of Diagnosis and Race/Ethnicity

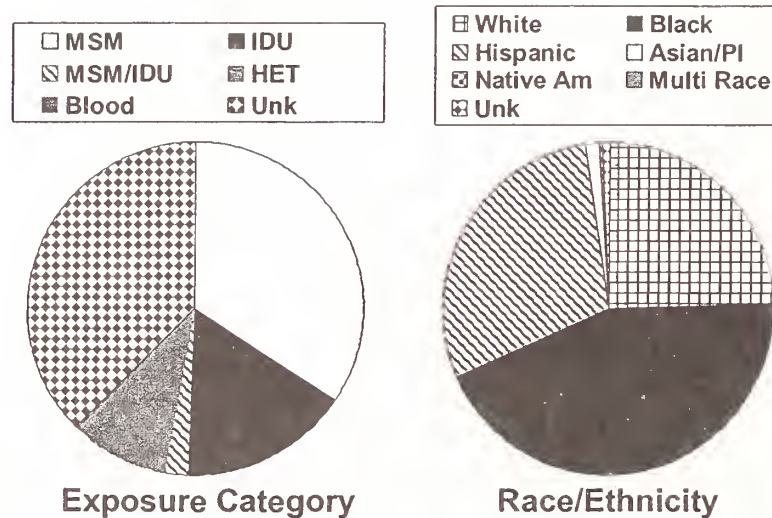
Data confirmed through December 31, 2004



AIDS Cases Among Adult Males Ages 25+ Diagnosed in 2002 by Exposure Category and Race/Ethnicity

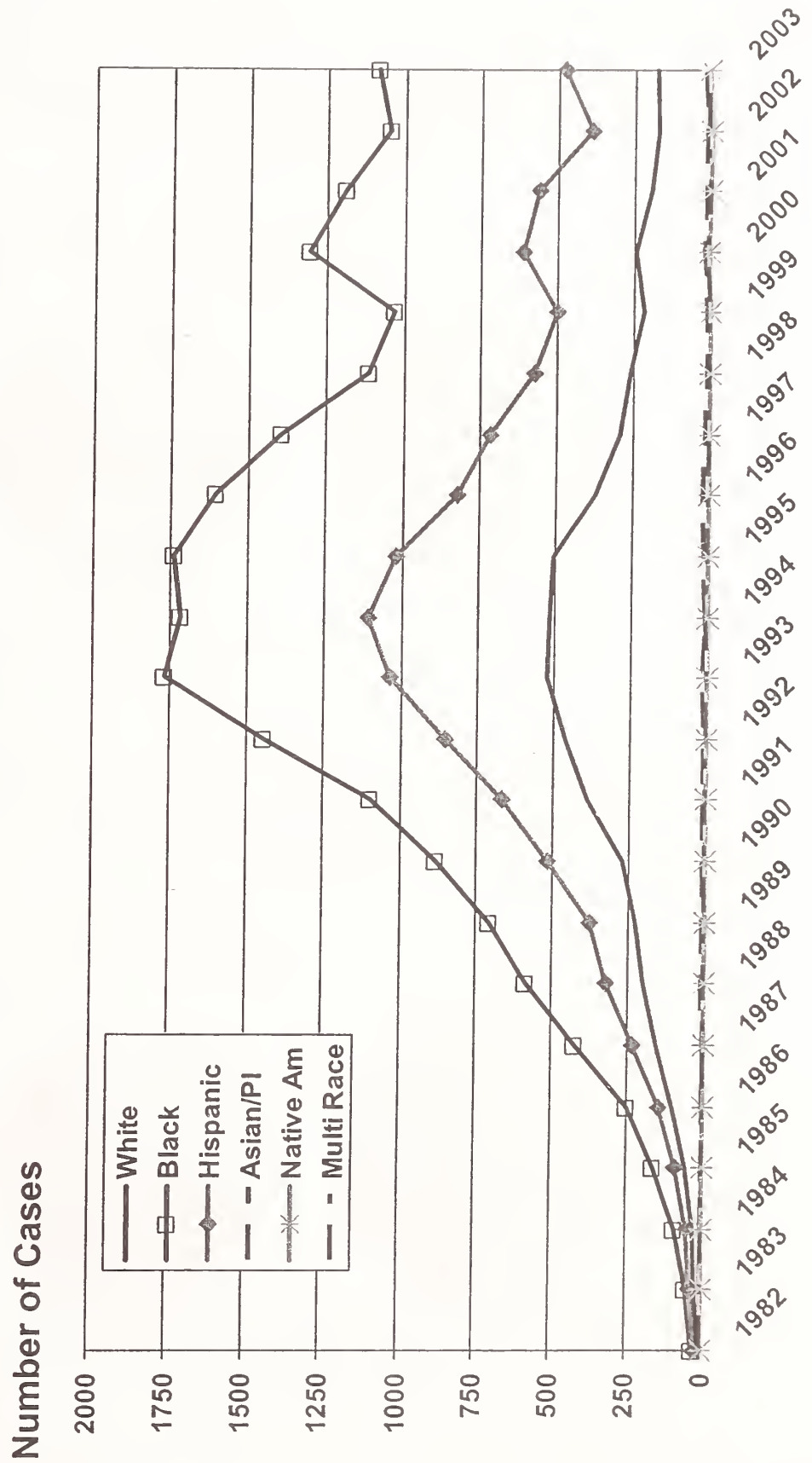


AIDS Cases Among Adult Males Ages 25+ Diagnosed in 2003 by Exposure Category and Race/Ethnicity

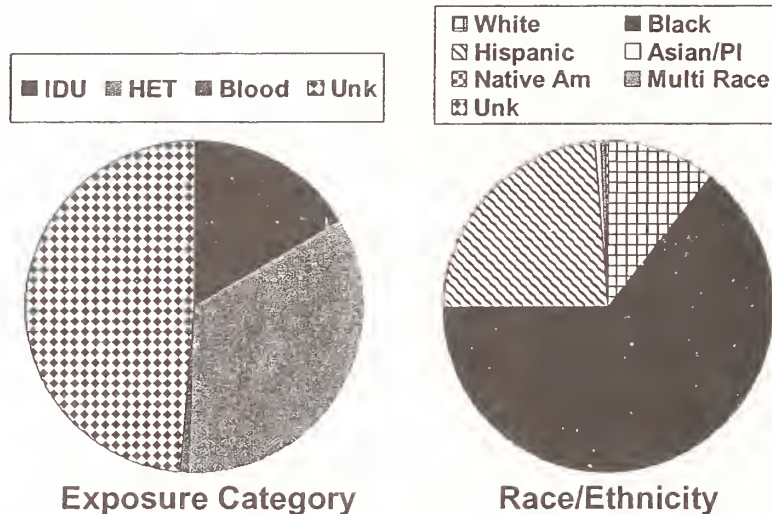


Cumulative NYS AIDS Cases Among Adult Females Ages 25+ by Year of Diagnosis and Race/Ethnicity

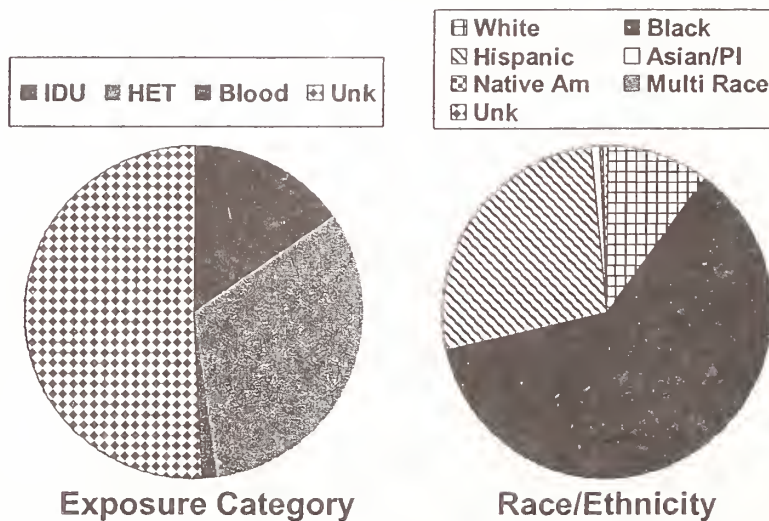
Data confirmed through December 31, 2004



AIDS Cases Among Adult Females Ages 25+ Diagnosed in 2002 by Exposure Category and Race/Ethnicity



AIDS Cases Among Adult Females Ages 25+ Diagnosed in 2003 by Exposure Category and Race/Ethnicity



**NYS Persons 50+ Years of Age Living with HIV/AIDS
by Gender, Race/Ethnicity, Age at Diagnosis, and Residence**

Descriptors	MSM	IDU	MSM/IDU	HETERO	BLOOD	UNK
Gender						
Male	1923	1920	145	551	58	2065
Female	0	443	0	813	45	907
Race/Ethnicity						
White	1033	254	24	187	31	494
Black	452	1375	77	735	40	1581
Hispanic	407	718	42	425	26	812
Asian/PI	25	4	0	13	4	39
NA/AN	3	0	0	0	1	2
2+ Races	2	7	1	2	0	6
Other/Unk	1	5	1	2	1	38
Age at Diagnosis						
50-54	1016	1500	91	667	33	1395
55-59	520	572	36	368	27	765
60-64	244	187	14	182	18	389
65-69	97	70	1	81	12	241
70+	46	34	3	66	13	182
Residence at Diagnosis						
New York City						
Bronx	151	528	20	261	22	612
Brooklyn	256	498	27	333	23	852
Manhattan	938	610	47	262	17	750
Queens	215	208	11	208	18	341
Staten Isl.	12	52	0	17	4	36
Upstate NY RWR						
Albany	35	55	3	13	4	49
Binghamton	9	5	0	2	0	3
Buffalo	46	34	8	43	2	21
Lower Hudson	69	107	7	95	2	44
Mid Hudson	32	112	5	42	1	42
Nassau/Suffolk	105	82	9	58	8	125
Rochester	23	40	7	12	1	47
Syracuse	32	32	1	18	1	50
Total	1923	2363	145	1364	103	2972

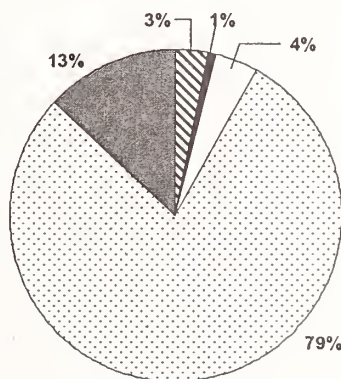
NYS AIDS Cases Diagnosed 2000-2003 Among Persons 50+ Years of Age by Gender, Race/Ethnicity, Age at Diagnosis, and Residence

Descriptors	MSM	IDU	MSM/IDU	HETERO	BLOOD	UNK
Gender						
Male	745	920	66	351	25	1357
Female	0	232	0	436	27	614
Race/Ethnicity						
White	394	130	13	105	12	260
Black	197	679	33	457	23	1151
Hispanic	140	333	20	213	13	519
Asian/PI	9	3	0	8	4	20
NA/AN	4	1	0	0	0	1
2+ Races	1	5	0	3	0	2
Other/Unk	0	1	0	1	0	18
Age at Diagnosis						
50-54	357	698	40	372	18	881
55-59	206	282	13	188	14	482
60-64	92	101	8	119	10	307
65-69	58	50	2	59	6	180
70+	32	21	3	49	4	121
Residence at Diagnosis						
New York City						
Bronx	55	248	10	140	13	448
Brooklyn	120	286	13	190	17	631
Manhattan	331	245	15	153	7	467
Queens	80	110	6	126	6	193
Staten Isl.	5	17	0	11	0	20
Upstate NY RWR						
Albany	14	26	4	6	3	28
Binghamton	1	3	0	1	1	2
Buffalo	27	28	7	33	1	12
Lower Hudson	30	55	4	55	0	42
Mid Hudson	19	59	2	25	1	12
Nassau/Suffolk	36	43	2	30	3	72
Rochester	14	17	2	7	0	27
Syracuse	13	15	1	10	0	17
Total	745	1152	66	787	52	1971

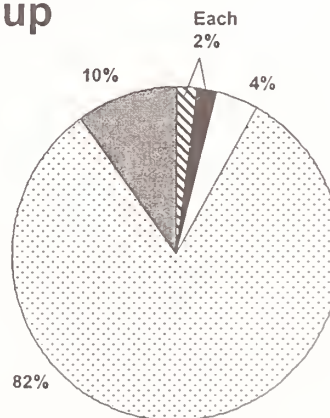
Persons Living with HIV/AIDS: Comparison of NYC to Upstate NY



Persons Living with HIV/AIDS: Comparison of NYC to Upstate NY by Age Group



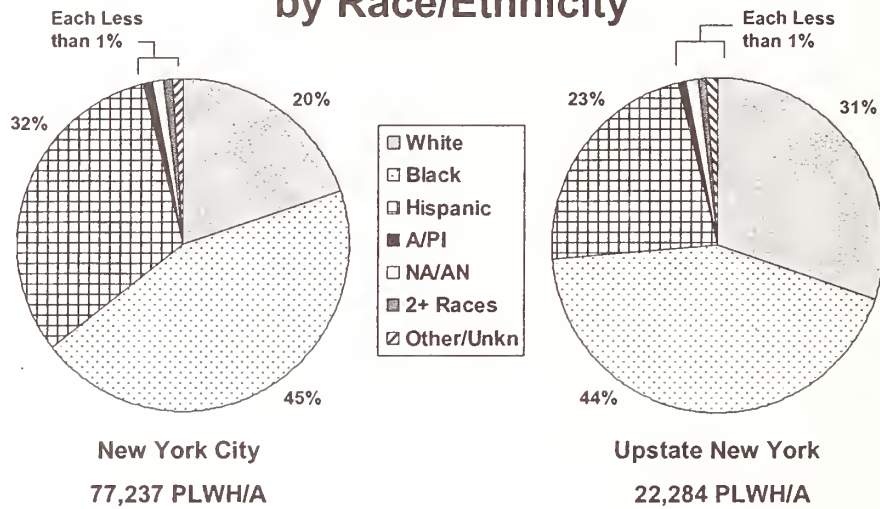
New York City
77,237 PLWH/A



Upstate New
22,284 PLWH/A

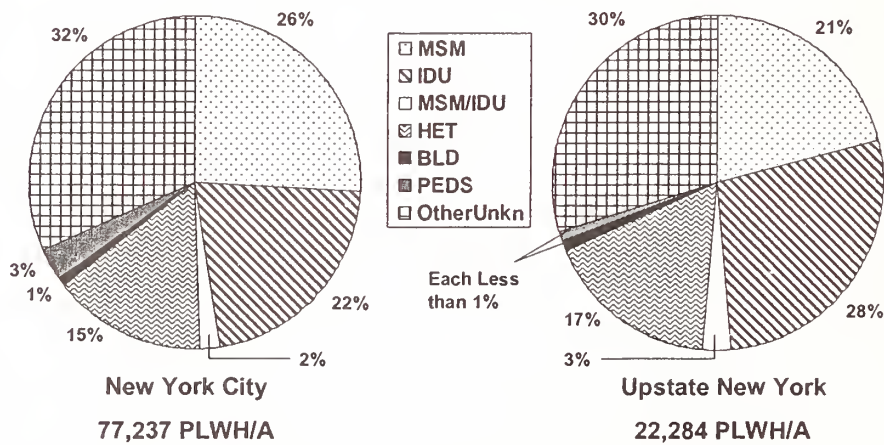
Note: Totals may not sum to 100% due to rounding

Persons Living with HIV/AIDS: Comparison of NYC to Upstate NY by Race/Ethnicity



Note: Totals may not sum to 100% due to rounding

Persons Living with HIV/AIDS: Comparison of NYC to Upstate NY by Transmission Category



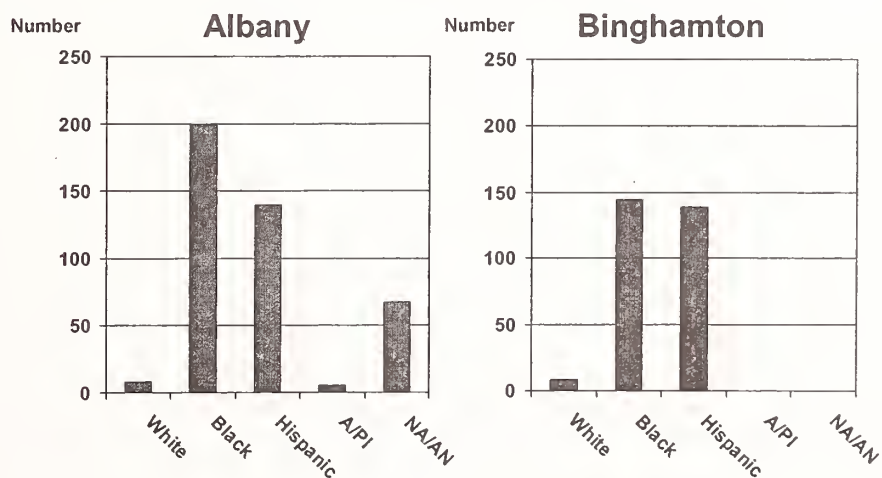
Note: Totals may not sum to 100% due to rounding

AIDS Cases Diagnosed During 2002 and 2003 by Race/Ethnicity and Ryan White Region

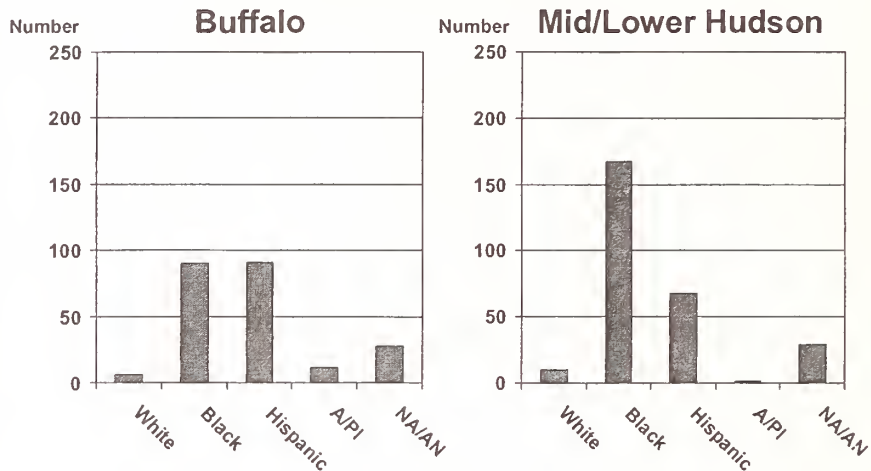


Bureau of HIV/AIDS Epidemiology
NYSDOH

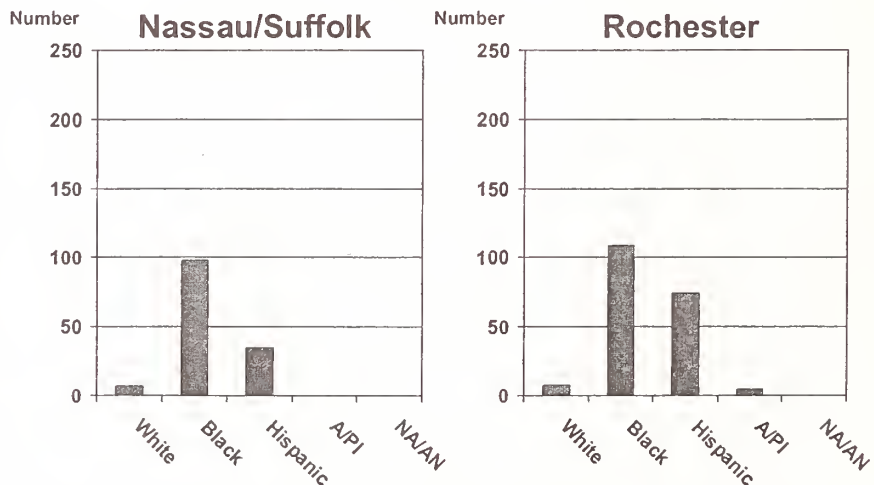
AIDS Cases Diagnosed During 2002 and 2003 by Race/Ethnicity and Ryan White Region (#1)



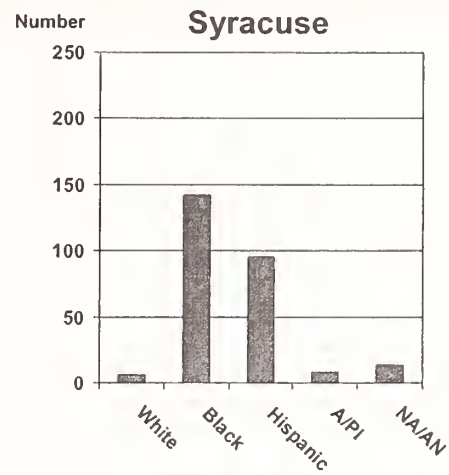
AIDS Cases Diagnosed During 2002 and 2003 by Race/Ethnicity and Ryan White Region (#2)



AIDS Cases Diagnosed During 2002 and 2003 by Race/Ethnicity and Ryan White Region (#3)



**AIDS Cases Diagnosed During 2002 and
2003 by Race/Ethnicity and Ryan White
Region (#4)**



**Adults Living with HIV/AIDS by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Confirmed through December 2004**

New York State

	Males						Females				
	Risk						Risk				
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR	
White											
13-19	48	3	3	3	7	34	7	47	0	32	
20-24	422	43	14	12	21	55	53	121	2	58	
25-29	1,372	170	62	56	21	250	164	237	6	155	
30-49	9,232	1,990	395	449	54	2,137	957	1,033	27	772	
50+	1,439	261	33	111	25	565	68	163	11	197	
Black											
13-19	173	12	2	19	2	118	24	126	3	252	
20-24	571	72	17	90	5	335	100	412	7	554	
25-29	1,026	274	63	203	9	804	309	808	16	918	
30-49	4,519	5,671	610	1,956	59	6,925	3,068	3,872	111	5,247	
50+	595	1,391	99	455	28	1,731	385	636	25	883	
Hispanic											
13-19	101	20	5	14	1	67	13	59	1	95	
20-24	485	160	29	60	4	227	100	238	1	228	
25-29	1,080	577	75	170	3	536	277	477	2	356	
30-49	4,167	5,153	440	1,065	33	4,384	1,923	2,201	47	1,970	
50+	527	788	47	211	19	941	153	392	16	429	
Asian/Pi											
13-19	4	0	0	0	0	2	1	3	0	2	
20-24	22	1	0	3	1	5	0	9	0	6	
25-29	64	4	2	6	0	29	0	16	0	27	
30-49	269	19	6	58	2	202	11	43	3	53	
50+	27	5	0	10	3	43	2	9	2	14	
Native Am.											
13-19	0	0	0	0	0	1	0	0	0	1	
20-24	2	0	0	0	0	1	0	3	0	4	
25-29	6	0	2	0	0	5	1	3	0	2	
30-49	21	6	3	8	0	23	7	9	1	8	
50+	7	1	0	0	0	2	0	0	1	0	
Total	26,179	16,621	1,907	4,959	297	19,422	7,623	10,917	282	12,263	

**Adults Living with HIV/AIDS by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Confirmed through December 2004**

New York City

	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	26	0	0	1	4	19	3	10	0	13
20-24	281	20	10	6	4	42	29	46	1	32
25-29	1,020	107	30	31	3	182	92	87	4	81
30-49	7,002	1,198	209	282	19	1,558	571	502	10	497
50+	1,092	179	22	64	9	426	47	97	9	155
Black										
13-19	136	7	2	12	2	86	15	88	2	205
20-24	461	46	9	64	4	259	69	292	7	495
25-29	840	185	42	151	8	602	233	607	12	801
30-49	3,753	3,935	388	1,489	44	5,249	2,260	2,906	95	4,582
50+	505	1,065	72	364	26	1,425	307	495	21	786
Hispanic										
13-19	88	13	3	12	1	57	11	46	1	80
20-24	437	116	25	48	3	180	80	190	1	207
25-29	966	380	67	131	3	406	219	395	2	310
30-49	3,799	4,010	359	881	27	3,139	1,636	1,870	43	1,721
50+	486	657	40	187	16	754	132	343	16	399
Asian/Pi										
13-19	3	0	0	0	0	1	1	3	0	2
20-24	20	1	0	3	1	5	0	6	0	5
25-29	60	4	2	5	0	25	0	14	0	24
30-49	258	18	3	52	1	187	9	42	2	48
50+	26	5	0	10	2	37	2	8	2	12
Native Am.										
13-19	0	0	0	0	0	1	0	0	0	1
20-24	2	0	0	0	0	0	0	0	0	2
25-29	3	0	2	0	0	3	0	1	0	0
30-49	10	2	1	5	0	9	2	5	0	5
50+	3	0	0	0	0	2	0	0	1	0
Total	21,277	11,948	1,286	3,798	177	14,654	5,718	8,053	229	10,463

**Adults Living with HIV/AIDS by Race/Ethnicity, Age at Diagnosis, Gender and Risk
Cases Confirmed through December 2004**

New York State Excluding NYC

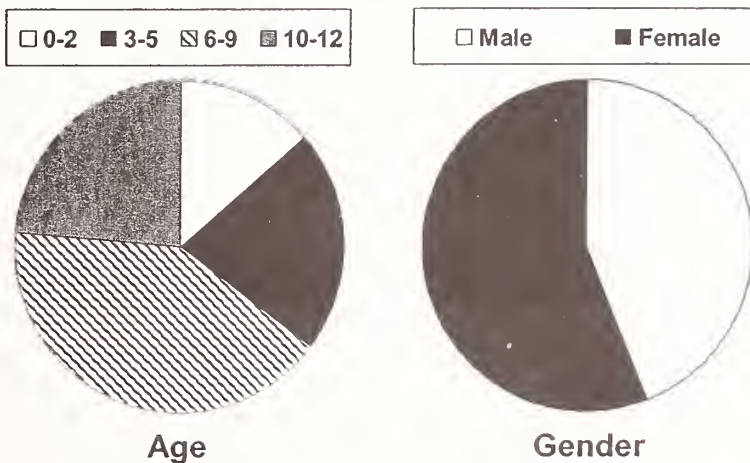
	Males						Females			
	Risk						Risk			
	MSM	IDU	MSM/ IDU	Hetero- sexual	Blood Products	NRR/ NIR	IDU	Hetero- sexual	Blood Products	NRR/ NIR
White										
13-19	22	3	3	2	3	15	4	37	0	19
20-24	141	23	4	6	17	13	24	75	1	26
25-29	352	63	32	25	18	68	72	150	2	74
30-49	2,230	792	186	167	35	579	386	531	17	275
50+	347	82	11	47	16	139	21	66	2	42
Black										
13-19	37	5	0	7	0	32	9	38	1	47
20-24	110	26	8	26	1	76	31	120	0	59
25-29	186	89	21	52	1	202	76	201	4	117
30-49	766	1,736	222	467	15	1,676	808	966	16	665
50+	90	326	27	91	2	306	78	141	4	97
Hispanic										
13-19	13	7	2	2	0	10	2	13	0	15
20-24	48	44	4	12	1	47	20	48	0	21
25-29	114	197	8	39	0	130	58	82	0	46
30-49	368	1,143	81	184	6	1,245	287	331	4	249
50+	41	131	7	24	3	187	21	49	0	30
Asian/Pi										
13-19	1	0	0	0	0	1	0	0	0	0
20-24	2	0	0	0	0	0	0	3	0	1
25-29	4	0	0	1	0	4	0	2	0	3
30-49	11	1	3	6	1	15	2	1	1	5
50+	1	0	0	0	1	6	0	1	0	2
Native Am.										
13-19	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	1	0	3	0	2
25-29	3	0	0	0	0	2	1	2	0	2
30-49	11	4	2	3	0	14	5	4	1	3
50+	4	1	0	0	0	0	0	0	0	0
Total	4,902	4,673	621	1,161	120	4,768	1,905	2,864	53	1,800

Pediatric AIDS Cases by Gender, Age at Diagnosis, Race/Ethnicity, and Mother's Transmission Category



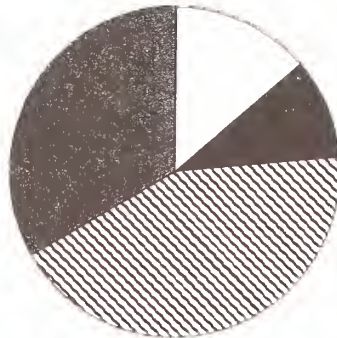
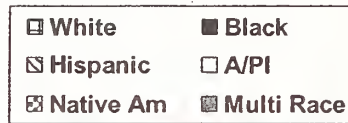
As Reported through 2004 by the
Bureau of HIV/AIDS Epidemiology
NYSDOH

Distribution of Pediatric AIDS Cases Diagnosed 2000 – 2003* by Age at Diagnosis and Gender

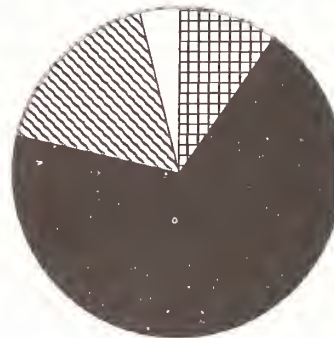


*Cases confirmed through December 2004

Distribution of Pediatric AIDS Cases Diagnosed 2000 – 2003* by Exposure Category and Race/Ethnicity



Exposure Category



Race/Ethnicity

*Cases confirmed through December 2004

**Pediatric AIDS Cases Diagnosed 2000-2003 by Race/Ethnicity,
Age at Diagnosis, Exposure Category, Rate per 100,000 Population and
NYS Geographic Region -- Cases Confirmed through December 2004**

			NYS
Race Ethnicity	NYS	NYC	excluding NYC
White	5	3	2
Black	35	29	6
Hispanic	9	9	0
Asian/PI	2	2	0
Exposure Category			
Mother HIV/AIDS	22	21	1
Mother IDU	7	5	2
Mother Sexually Exposed	5	4	1
Other/Undetermined	17	13	4
Age at Diagnosis			
0-2	7	6	1
3-5	11	8	3
6-9	21	21	0
10-12	12	8	4
Total	51	43	8

**Perinatally-Infected Persons Living with HIV/AIDS
by Race/Ethnicity, Gender and Ryan White Region
NYS, Cases Confirmed through December 2004**

	Number	Percent
Race/Ethnicity		
White	356	8.62
Black	2,349	56.86
Hispanic	1,339	32.41
Asian/PI	16	0.39
Native Am.	4	0.10
Multi Race	3	0.07
Unk	64	1.55
Total	4,131	100.00
Gender		
Male	2,064	49.96
Female	2,067	50.04
Total	4,131	100.00
Ryan White Region		
Albany	62	1.50
Binghamton	7	0.17
Buffalo	35	0.85
Low Hudson	130	3.15
Mid Hudson	66	1.60
Nassau Suffolk	206	4.99
NYC	3,559	86.15
Rochester	36	0.87
Syracuse	30	0.73
Total	4,131	100.00

Data Further Describing NYS



**New York State and Counties as compared to
the District of Columbia and other States**

Data through December 2003

**I. New York State and Counties Rank among other states by
Persons Living with AIDS**

- 1] New York State exceeds all states and the District of Columbia in number of persons living with AIDS (PLWAs): 66,660
- 2] New York County, a borough of New York City, has a larger number of PLWAs than 45 states and the District of Columbia. Of the 5 states that exceed New York County in PLWAs, one is New York State, the state in which this county is located.
- 3] Kings County, the borough of New York City known as Brooklyn, has a larger number of PLWAs than 42 states and the District of Columbia. Of the 8 states that exceed Kings County in PLWAs, one is New York State, the state in which this county is located.
- 4] Bronx County, a borough of New York City, has a larger number of PLWAs than 41 states and the District of Columbia. Of the 9 states that exceed New York County in PLWAs, one is New York State, the state in which this county is located.
- 5] Queens County, a borough of New York City, has a larger number of PLWAs than 40 states. Of the 10 states that exceed Queens County in PLWAs, one is New York State, the state in which this county is located. The District of Columbia also exceeds Queens County in number of PLWAs.
- 6] Westchester County exceeds 28 states in number of PLWAs. Of the 22 states that exceed Westchester County, one is New York State, the state in which this county is located. The District of Columbia also exceeds Westchester County in number of PLWAs.
- 7] Nassau and Suffolk Counties, with 1,450 and 1,445 PLWAs, respectively, exceed 17 states in number of persons living with AIDS.
- 8] Richmond County, a borough of New York City known as Staten Island, and Monroe and Erie Counties, with 985, 957, and 857 PLWAs respectively, each exceed 18 states in number of persons living with AIDS.
- 9] Dutchess County, with 630 PLWAs, exceeds 10 states in number of persons living with AIDS.

**II. New York State and Counties Rank among other states by
Cumulative AIDS Cases**

- 1] New York State exceeds all states and the District of Columbia in number of cumulative AIDS cases: 162,446 cases.
- 2] New York and Kings Counties, boroughs of New York City known as Manhattan and Brooklyn respectively, each have a larger number of cumulative AIDS cases than 45 states and the District of Columbia. Of the 5 states that exceed New York and Kings Counties in cumulative AIDS cases, one is New York State, the state in which these counties are located.
- 3] Bronx County, a borough of New York City, has a larger number of cumulative AIDS cases than 42 states and the District of Columbia. Of the 8 states that exceed Bronx County in cumulative AIDS cases, one is New York State, the state in which this county is located.
- 4] Queens County, a borough of New York City, has a larger number of cumulative AIDS cases than 40 states and the District of Columbia. Of the 10 states that exceed Queens County in cumulative AIDS cases, one is New York State, the state in which this county is located.
- 5] Westchester County exceeds 28 states in number of cumulative AIDS cases. Of the 22 states that exceed Westchester County, one is New York State, the state in which this county is located. The District of Columbia also exceeds Westchester County in number of cumulative AIDS cases.
- 6] Nassau and Suffolk Counties, with 3,725 and 3,696 cases, respectively, exceed 19 states in number of cumulative AIDS cases.
- 7] Richmond County, a borough of New York City known as Staten Island, with 2,701 cases, exceeds 16 states in number of cumulative AIDS cases.
- 8] Monroe and Erie Counties, with 2,061 and 1,973 cases, respectively, exceed 12 states in number of cumulative AIDS cases.
- 9] Dutchess County, with 1,497 cases, exceeds 11 states in number of cumulative AIDS cases.
- 10] Orange (1,289 cases), Onondaga (1052), Albany (1,032 cases), Rockland (911 cases), Oneida (909 cases), Ulster (877 cases), and Sullivan (622 cases) Counties each exceed 7 or more states in number of cumulative AIDS cases.

III. New York State and Counties Rank among other states by HIV Name-Reporting Initiation Date

In New York State HIV-Named Reporting was initiated on June 1, 2000. Only 2 states have more recent initiation dates, Pennsylvania (excluding Philadelphia) in 2002 and Georgia in 2003.

New York State, the third youngest HIV-Named Reporting system, has reported the greatest number of HIV cases, as compared to other states, in the US during these 3.5 years of HIV-Named-reporting: 36,062.

NB: Connecticut is excluded from this list as the state reports only Pediatric HIV cases.

IV. New York State and Counties Rank among other states by Cumulative HIV Cases

Among the 35 states with HIV-Named Reporting currently included in Table 16 of the CDC HIV/AIDS Surveillance Report –2003, New York State has reported the greatest number of HIV cases: 36,062 cases.*

* Connecticut is excluded from this ranking as the state reports only Pediatric HIV cases.

V. New York State and Counties Rank among other states by Mean Annual HIV Cases Reported per Year of Named-Reporting

Among the 35* states with HIV-Named Reporting currently included in Table 16 of the CDC HIV/AIDS Surveillance Report -- 2003, the length of time HIV-Named Reporting has been in place varies from 0 years, Georgia, to 18 years (1985 through 2003), Minnesota.

Dividing the total number of HIV cases reported by the number of years of HIV-Named Reporting yields the Mean Annual HIV Cases Reported per Year of Named-Reporting.

New York State, as compared to other states, has the greatest Mean annual HIV cases reported per year of HIV-Named Reporting: 12,020.67 cases.

- * Connecticut is excluded from this ranking as the state reports only Pediatric HIV cases.

References:

Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report – 2003* (Vol.15). Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2004: 1-46.

Also available at:

<http://www.cdc.gov/hiv/stats/hasrlink.htm>

Bureau of HIV/AIDS Epidemiology, New York State HIV/AIDS Surveillance Semiannual Report – 2003. New York State Department of Health; 2005:1-59.

Also available at:

http://www.health.state.ny.us/diseases/aids/statics/semiannual/2003/surveillance/2003/surveillance_semiannual_report_2003.pdf

Ranked Chronologically by HIV-Named Reporting Initiation Date

Rank	State	Year HIV Reporting Initiated	Number HIV Cases Reported	Number Years Reporting	Mean HIV Reported per Year
1	Minnesota	1985	3291	18	182.83
2	Colorado	1985	6323	18	351.28
3	Wisconsin	1985	2540	18	141.11
4	South Carolina	1986	7635	17	449.12
5	Idaho	1986	433	17	25.47
6	Arizona	1987	5399	16	337.44
7	Missouri	1987	5019	16	313.69
8	Alabama	1988	6110	15	407.33
9	North Dakota	1988	85	15	5.67
10	South Dakota	1988	228	15	15.20
11	Oklahoma	1988	2704	15	180.27
12	Indiana	1988	4031	15	268.73
13	Mississippi	1988	4602	15	306.80
14	West Virginia	1989	713	14	50.93
15	Utah	1989	698	14	49.86
16	Wyoming (State of)	1989	96	14	6.86
17	Arkansas	1989	2311	14	165.07
18	Virginia	1989	9636	14	688.29
19	North Carolina	1990	12586	13	968.15
20	Ohio	1990	7527	13	579.00
21	New Jersey	1992	16805	11	1527.73
22	Tennessee	1992	6897	11	627.00
23	Nevada	1992	3510	11	319.09
24	Michigan	1992	6325	11	575.00
25	Louisiana	1993	8164	10	816.40
26	Nebraska	1995	612	8	76.50
27	Florida	1997	31497	6	5249.50
28	New Mexico	1998	778	5	155.60
29	Iowa	1998	471	5	94.20
30	Texas	1999	18398	4	4599.50
31	Alaska	1999	279	4	69.75
32	Kansas	1999	1134	4	283.50
33	New York (State of)	2000	36062	3	12020.67
34	Pennsylvania (not including Philadelphia)	2002	3303	1	3303.00
35	Georgia	2003	515	0	515.00

(36 Connecticut - Not included due to reporting Peds cases only)

Sorted by Cumulative Number of HIV Cases Reported

Rank	State	Year HIV Reporting Initiated	Number HIV Cases Reported	Number Years Reporting	Mean HIV Reported per Year
1	New York (State of)	2000	36062	3	12020.67
2	Florida	1997	31497	6	5249.50
3	Texas	1999	18398	4	4599.50
4	New Jersey	1992	16805	11	1527.73
5	North Carolina	1990	12586	13	968.15
6	Virginia	1989	9636	14	688.29
7	Louisiana	1993	8164	10	816.40
8	South Carolina	1986	7635	17	449.12
9	Ohio	1990	7527	13	579.00
10	Tennessee	1992	6897	11	627.00
11	Michigan	1992	6325	11	575.00
12	Colorado	1985	6323	18	351.28
13	Alabama	1988	6110	15	407.33
14	Arizona	1987	5399	16	337.44
15	Missouri	1987	5019	16	313.69
16	Mississippi	1988	4602	15	306.80
17	Indiana	1988	4031	15	268.73
18	Nevada	1992	3510	11	319.09
19	Pennsylvania (not including Philadelphia)	2002	3303	1	3303.00
20	Minnesota	1985	3291	18	182.83
21	Oklahoma	1988	2704	15	180.27
22	Wisconsin	1985	2540	18	141.11
23	Arkansas	1989	2311	14	165.07
24	Kansas	1999	1134	4	283.50
25	New Mexico	1998	778	5	155.60
26	West Virginia	1989	713	14	50.93
27	Utah	1989	698	14	49.86
28	Nebraska	1995	612	8	76.50
29	Georgia	2003	515	0	515.00
30	Iowa	1998	471	5	94.20
31	Idaho	1986	433	17	25.47
32	Alaska	1999	279	4	69.75
33	South Dakota	1988	228	15	15.20
34	Wyoming (State of)	1989	96	14	6.86
35	North Dakota	1988	85	15	5.67

(36 Connecticut - Not included due to reporting Peds cases only)

States sorted by Mean HIV cases per year of HIV-Named Reporting

Rank	State	Year HIV Reporting Initiated	Number HIV Cases Reported	Number Years Reporting	Mean HIV Reported per Year
1	New York (State of)	2000	36062	3	12020.67
2	Florida	1997	31497	6	5249.50
3	Texas	1999	18398	4	4599.50
4	Pennsylvania (not including Philadelphia)	2002	3303	1	3303.00
5	New Jersey	1992	16805	11	1527.73
6	North Carolina	1990	12586	13	968.15
7	Louisiana	1993	8164	10	816.40
8	Virginia	1989	9636	14	688.29
9	Tennessee	1992	6897	11	627.00
10	Ohio	1990	7527	13	579.00
11	Michigan	1992	6325	11	575.00
12	Georgia	2003	515	0	515.00
13	South Carolina	1986	7635	17	449.12
14	Alabama	1988	6110	15	407.33
15	Colorado	1985	6323	18	351.28
16	Arizona	1987	5399	16	337.44
17	Nevada	1992	3510	11	319.09
18	Missouri	1987	5019	16	313.69
19	Mississippi	1988	4602	15	306.80
20	Kansas	1999	1134	4	283.50
21	Indiana	1988	4031	15	268.73
22	Minnesota	1985	3291	18	182.83
23	Oklahoma	1988	2704	15	180.27
24	Arkansas	1989	2311	14	165.07
25	New Mexico	1998	778	5	155.60
26	Wisconsin	1985	2540	18	141.11
27	Iowa	1998	471	5	94.20
28	Nebraska	1995	612	8	76.50
29	Alaska	1999	279	4	69.75
30	West Virginia	1989	713	14	50.93
31	Utah	1989	698	14	49.86
32	Idaho	1986	433	17	25.47
33	South Dakota	1988	228	15	15.20
34	Wyoming (State of)	1989	96	14	6.86
35	North Dakota	1988	85	15	5.67

(36 Connecticut - Not included due to reporting Peds cases only)

Counseling and Testing



Counseling and Testing

The Bureau of Direct Program Operations operates HIV counseling and testing sites in state and county correctional facilities and in the community throughout NYS. All testing is undertaken and conducted as anonymous, however, upon receiving his/her test result, the individual is offered the opportunity to “convert” from anonymous to confidential testing status. This “conversion,” if elected, allows the individual to leave the post-test counseling session with documentation of test results that, in turn, facilitates access to medical care and follow-up. Conversion is entirely voluntary and there is no penalty to maintaining anonymity. Results and data from anonymous testing are reported only in the aggregate; personal identifiers are reported to the HIV and AIDS registries in confidential testing.

Anonymous Counseling and Testing at Correctional Facilities January through December 2003

I. Anonymous Counseling and Testing at State Correctional Facilities January through December 2003

In the NYS Department of Correctional Services Facilities, the HIV Counseling and Testing Programs 7,015 inmates tested during Calendar Year 2003; the following information describes these participants:

▪ Gender:	Males	97.2%
	Females	2.8
▪ Age Groups:	Less than 20	3.4%
	20 to 29	43.7
	30 to 39	31.6
	40 to 49	16.3
	50 and older	4.3
	Age Unknown	0.6
▪ Racial/Ethnic Distribution	White	17.7%
	Black	47.3
	Hispanic	31.3

	Asian/Pacific Islander	0.5
	American Indian/ Alaskan Native	0.8
	Unknown Race/ Ethnicity	2.5
▪ HIV Risk	MSM	2.3%
	IDU	6.7
	MSM/IDU	0.3
	Sex Partner At Risk	4.0
	Exchanged Sex for Drugs/Money	7.2
	Have/Had STD	17.3
	Heterosexual	60.8
	Other Risk	0.5
	Unknown/ Missing	1.0
▪ Received Post- Test Counseling/ HIV Test Result	Yes	96.8%
	No	3.2
▪ Percent participants receiving HIV+ Results		0.7%

II. Anonymous Counseling and Testing at County Correctional Facilities January through December 2003

Under the same procedures as described above, the Bureau of Direct Program Operations also offer anonymous counseling and testing for HIV infection in selected county-level correctional facilities throughout NYS. During 2003, 1,675 county inmates participated in this service. Descriptors for this group include:

▪ Gender:	Males	72.7%
	Females	27.3

▪ Age Groups:	Less than 20	7.4%
	20 to 29	36.8
	30 to 39	29.5
	40 to 49	20.8
	50 and older	5.4
	Age Unknown	0.1
▪ Racial/Ethnic Distribution	White	34.4%
	Black	50.3
	Hispanic	11.7
	Asian/Pacific	
	Islander	0.2
	American Indian/ Alaskan Native	1.1
	Unknown Race/ Ethnicity	2.3
▪ HIV Risk	MSM	2.6%
	IDU	12.5
	MSM/IDU	0.5
	Sex Partner	
	At Risk	7.0
	Exchanged Sex for Drugs/Money	9.2
	Have/Had STD	18.6
	Heterosexual	48.7
	Other Risk	0.4
	Unknown/ Missing	0.4
▪ Received Post- Test Counseling/ HIV Test Result	Yes	92.0%
	No	8.0
▪ Percent participants receiving HIV+ Results		
		0.9%

III. Total State and County Correctional Sites
HIV Counseling and Testing
January through December 2003

- Total participants
receiving post-test
counseling 95.9%
- Total Participants
Converting from anonymous
to confidential testing
upon receiving their
HIV test result 91.9%
- Total participants who
had previously tested 76.1%

**Anonymous HIV Counseling and Testing Program
Community Sites
January through December 2003**

I. Community sites in NYS provided HIV Counseling and Testing to 10,955 individuals during Calendar Year 2003; the following information describes these participants:

▪ Number (%) of Participants

By Ryan White Region:

	<u>Number</u>	<u>Percent</u>
Buffalo	1,642	15
Rochester	1,117	10
Syracuse	1,620	15
Albany	2,013	18
Mid/Lower Hudson	719	7
Nassau	2,251	21
Suffolk	1,593	15
Total	10,955	100

▪ Gender: Males 57.7%
Females 42.3

▪ Age Groups: Less than 20 5.3%
20 to 29 34.1
30 to 39 25.8
40 to 49 23.1
50 and older 11.2
Age Unknown 0.6

▪ Racial/Ethnic Distribution

White	50.4%
Black	31.0
Hispanic	14.0
Asian/Pacific Islander	2.1
American Indian/Alaskan Native	0.6
Unknown Race/ • Ethnicity	2.0

▪ HIV Risk MSM 12.6%

IDU	5.3
MSM/IDU	0.5
Sex Partner	
At Risk	7.0
Exchanged Sex for	
Drugs/Money	4.9
Have/Had STD	13.0
Heterosexual	55.3
Other Risk	0.8
Unknown/	
Missing	0.6

- Received Post-Test Counseling/
 HIV Test Result

Yes	87.1%
No	12.9
- Percent participants
 Receiving HIV+ Results

1.0%

II. Total Community Sites
 HIV Counseling and Testing
 January through December 2003

- Total participants
 receiving post-test
 counseling

87.4%

- Total Participants
 Converting from anonymous
 to confidential testing
 upon receiving their
 HIV test result

72.6%

- Total participants who
 had previously tested

66.9%

HIV/AIDS as a Leading Cause of Death:

What does this data tell us about the epidemic?

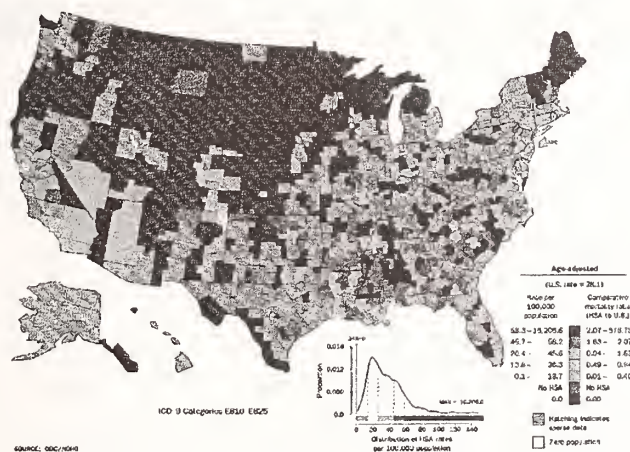
Jurisdictions at all levels use mortality information to better understand the effects of health conditions on communities. The top five or ten leading causes of death are very helpful in characterizing the health interventions needed improve overall community health. This improvement is made by decreasing the risk to and morbidity of those persons in the community affected by the conditions with the highest mortality.

When reading 'Leading Cause of Death' tables, read the title carefully to know which group is being described. The following are two examples:

- 1] Residents of Kentucky, all ages, all races, all ethnicities, and all genders
- 2] Latino men, ages 20-50 years, in Minneapolis

Once you determine the group of interest, there are a number of methods used to display the data.

Mapping



The density of mortality due to one or more conditions is particularly easy to visualize and use when in map format. Mapping also allows easy comparisons from one condition to another and from one time period to another. [The map displayed here is an example only.]

Tables

Mortality due to the leading causes of death is also presented in table format. In this type of display a number indicating the mortality rank is placed in the table at the location describing the population of interest. If no number is displayed, the disease or diseases of interest are *not* among the top five or top 10 causes of death for that population. The data on the following page is in table format.

AIDS as One of 10 Leading Causes of Death By Gender and Race/Ethnicity New York State - 2002

Males

	Racial/Ethnic Groups*			
	All Persons	White	Black	Hispanic
All Ages	8		3	3
<1 Year of Age				
1 to 9				
10 to 14				5
15 to 24	7		6	5
25 to 34	6	6	3	3
35 to 44	3	5	1	1
45 to 54	3	6	3	
55 to 64	8		5	3
65 to 74			9	10
75+				

Females

	Racial/Ethnic Groups*			
	All Persons	White	Black	Hispanic
All Ages			6	6
<1 Year of Age				
1 to 9				
10 to 14			6	
15 to 24	7		5	5
25 to 34	3	7	1	1
35 to 44	2	4	1	1
45 to 54	3		3	3
55 to 64			8	5
65 to 74				
75+				

* Data for Asian and Pacific Islanders , Native American/Alaskan Native, and individuals of 2+ Races is not available in the same format and from the same source. Please see the **Data Availability Notice** in Visual Display of Racial/Ethnic Data for details.

Example: AIDS is the 3rd leading cause of death for all females ages 25-34 in NYS, but it is the leading cause (#1) of death for Black and Hispanic females in the same age group

AIDS Mortality in New York State



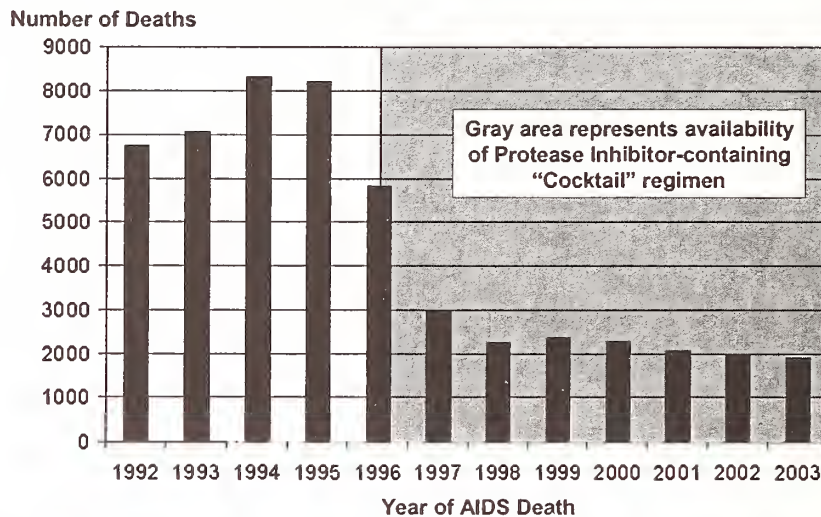
Data Notes on AIDS Mortality

- The following slides describe AIDS Mortality by both *number of deaths* and by *rate per 100,000 population*. When comparing one slide to another, be sure that both slides use the same unit of comparison
- The last three slides show the changes in number of AIDS deaths, by gender, between January of 1997 and December of 2003 in three geographic areas:
 - New York State
 - New York City
 - Upstate New York
(New York State excluding New York City)
- When comparing these graphs, be sure to look at the scale, the vertical axis on the left side of the graph. On the NYS slide the scale is 0 to 2,500; on the NYC slide it is 0 to 2,000; and on the Upstate slide it is 0 to 400

Annual AIDS Deaths

New York State -- 1992 through 2003

Data from the Bureau of Biometrics, NYSDOH



New York State AIDS Death Rate per 100,000 Population

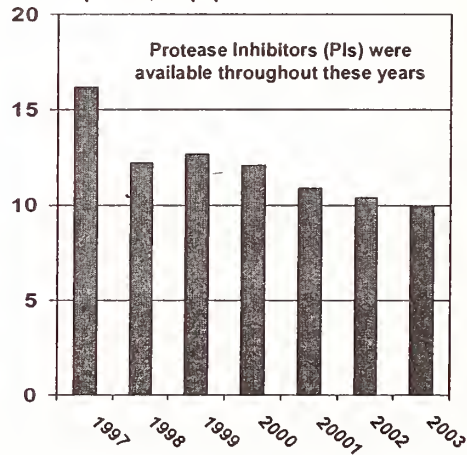
Selected Years -- 1997 through 2003

Data from the Bureau of Biometrics, NYSDOH

Prior to mid-1996, "cocktails" containing a PI were only available to people living with HIV/AIDS through research projects

After mid-1996, large numbers of PLWAIDS/HIVs in NYS began these new medication combinations. The death rate per 100,000 population continues to drop as increasing numbers of clinicians prescribe these medications and as the importance of adherence is better understood

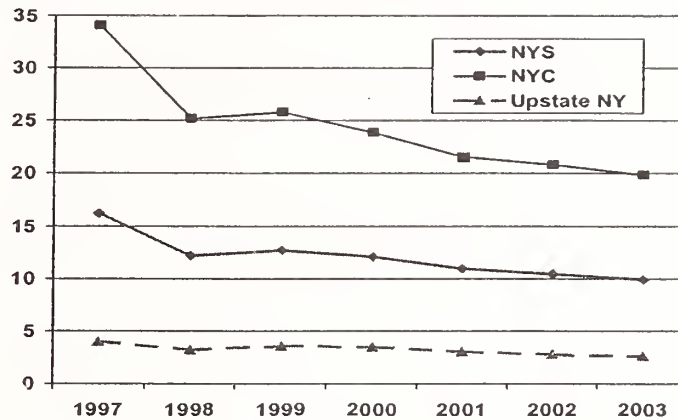
Death Rate per 100,000 population



New York State AIDS Death Rate per 100,000 Population by Geographic Area Selected Years – 1997 through 2003

Data from the Bureau of Biometrics, NYSDOH

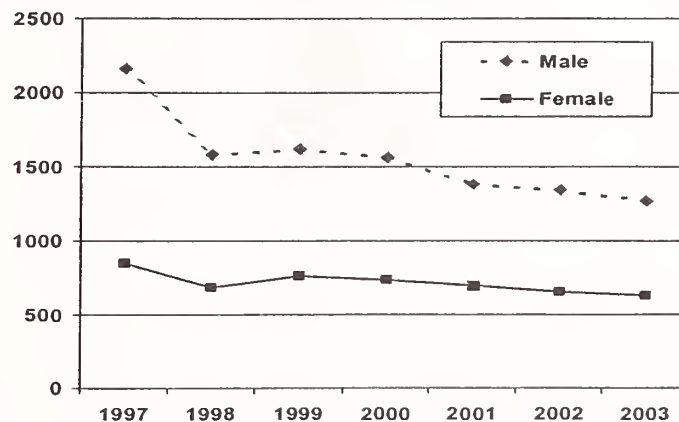
Death Rate per 100,000 population



AIDS Deaths by Gender and Geography Selected Years – 1997 through 2003

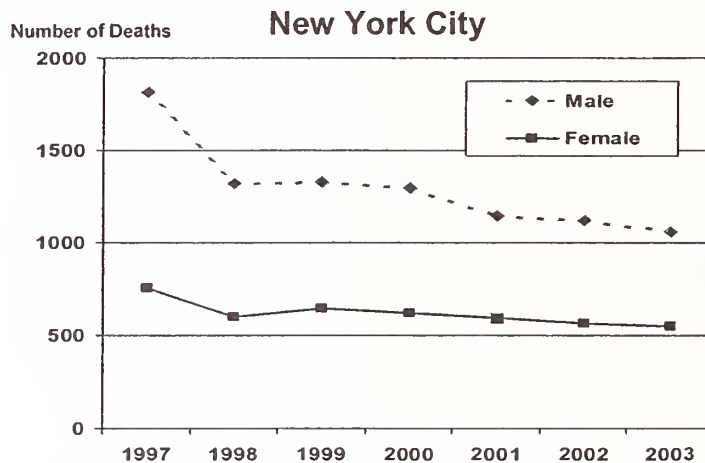
Data from the Bureau of Biometrics, NYSDOH

Number of Deaths New York State



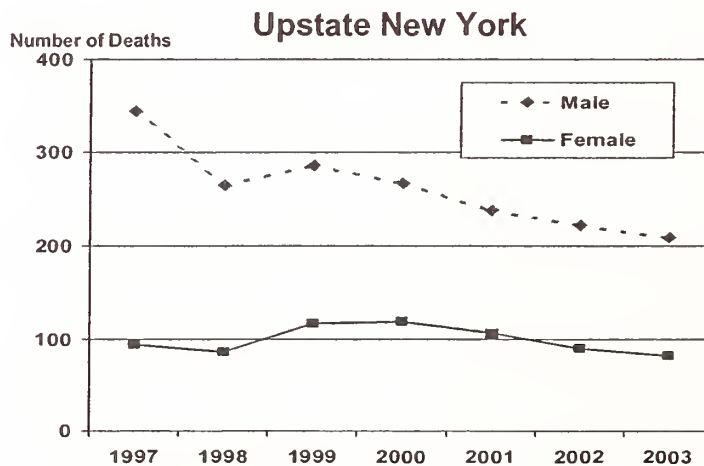
AIDS Deaths by Gender and Geography Selected Years – 1997 through 2003

Data from the Bureau of Biometrics, NYSDOH



AIDS Deaths by Gender and Geography Selected Years – 1997 through 2003

Data from the Bureau of Biometrics, NYSDOH



Please proceed to Volume 2



HIV/AIDS

Epidemiologic Profile

New York State

2005-2006



Prepared for the
New York State HIV Prevention Planning Group
by the
Division of HIV Prevention
AIDS Institute
New York State Department of Health

Volume 2 of 2

MH08D8577



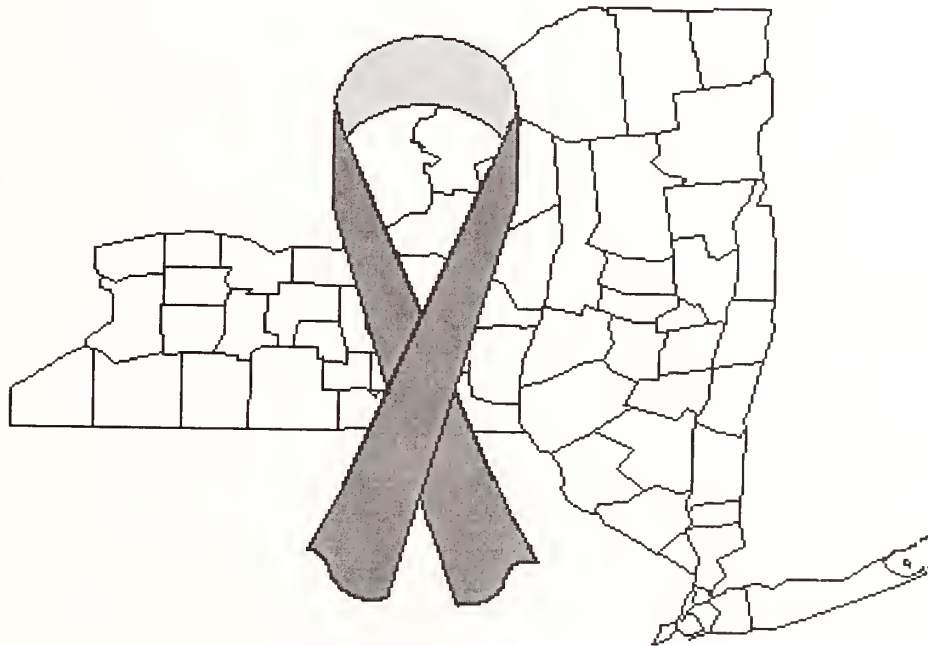
Office of Minority Health Resource Center
Knowledge Center
1101 Wootton Parkway
Rockville, MD 20852
1-800-444-6472

HIV/AIDS

Epidemiologic Profile

New York State

2005-2006



Prepared for the
New York State HIV Prevention Planning Group
by the
Division of HIV Prevention
AIDS Institute
New York State Department of Health

Volume 2





Volume 1

Table of Contents

Dedication	i
Acknowledgements	iii
Table of Contents	v
Introduction to the 2005-2006 Epidemiologic Profile	xiii
Visual Display of Racial/Ethnic Data: Data Availability Notice	xv
 Question 1: What are the sociodemographic characteristics of the general population in New York State?	 1-1
Introduction	1-3
New York State Demographics and Geography	1-5
Key Geographical Markers and Locales in NYS	1-6
Major Urban Centers	1-7
New York State and Major Urban Centers by Race/Ethnicity	1-7
Census 2000 Populations for Boroughs and Counties of NYS	1-8
Rural, Suburban, and Urban Population Distribution	1-9
Northeast Corridor	1-9

Native American Nations, Territories, Reservations, and Villages	1-10
Native American and Alaskan Natives in NYS by Place of Residence	1-11
Native American/Alaskan Native Population in New York State by County	1-12
Vital Statistics in NYS	1-13
A Day in the Life of New York State	1-13
New York State Population by Age Group	1-14
Poverty Level and Median Household Income	1-14
New York State by Federal Poverty Level	1-15
Poverty Level by Age and Family Status in NYS	1-16
Boroughs and Counties of NYS by Estimated Number and Percent of Residents Living in Poverty	1-17
Federal Poverty Level by Age Group	1-18
Federal Poverty Level by Race/Ethnicity	1-19
The Foreign-born in NYS	1-19
Foreign-Born 5 Years of Age and Older Residing in NYS by Region of Birth	1-20
Languages Spoken at Home in NYS	1-20
Educational Attainment	1-21
Health Insurance Coverage	1-22
NYS Population by Insurance Status	1-22
Distribution of Nonelderly Uninsured by Federal Poverty Level	1-23
Distribution of Nonelderly Uninsured in NYS by Race/Ethnicity	1-24
References for Question 1	1-26

Question 2: What is the scope of the HIV/AIDS epidemic in New York State?	2-1
Introduction	2-3
Data Notes	2-5
Data Issue: The Growth of “Other/NIR/NRR”	2-7
CDC Transmission Category Hierarchy	2-8
New York State HIV/AIDS Surveillance Semiannual Report – June 30, 2004	2-11
Graphic Display of NYS Descriptive Data	2-43
2004 Epidemiologic Profile of New York State by Geography, Ryan White Region, and New York City Borough	2-37
New York State	2-45
New York City	2-49
Borough of the Bronx	2-53
Borough of Brooklyn	2-57
Borough of Manhattan	2-61
Borough of Queens	2-65
Borough of Staten Island	2-69
New York State Excluding New York City (Upstate NY)	2-73
Albany (Northeast, Capital) Ryan White Region	2-77
Binghamton Ryan White Region	2-81
Buffalo Ryan White Region	2-85
Lower Hudson Ryan White Region	2-89
Mid-Hudson Ryan White Region	2-93
Nassau/Suffolk Ryan White Region	2-97
Rochester Ryan White Region	2-101
Syracuse Ryan White Region	2-105

Data Interpretation: Examples for Use with Question 2 Data and Materials	2-109
Data Further Describing New York	2-117
NYS AIDS Cases by Transmission Category, Year of Diagnosis: Ryan White Regions and Boroughs of New York City – 1993 to 2003	2-119
Cumulative Adult AIDS Cases in NYS by Race/ Ethnicity, Age at Diagnosis, Gender, and Risk Data through 2003	2-136
Cumulative Adult AIDS Cases in NYS by Race/ Ethnicity, Age at Diagnosis, Gender, and Risk Data through 2003	2-137
Cumulative Adult AIDS Cases in NYS excluding NYC (Upstate NY) by Race/Ethnicity, Age at Diagnosis, Gender, and Risk - Data through 2003	2-138
Cumulative Adult HIV Cases in NYS by Race/ Ethnicity, Age at Diagnosis, Gender, and Risk Data through 2003	2-139
Cumulative Adult HIV Cases in NYC by Race/ Ethnicity, Age at Diagnosis, Gender, and Risk Data through 2003	2-140
Cumulative Adult HIV Cases in NYS excluding NYC (Upstate NY) by Race/Ethnicity, Age at Diagnosis, Gender, and Risk - Data through 2003	2-141
NYS Adult AIDS Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-142
NYC Adult AIDS Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-143
NYS (excluding NYC) Adult AIDS Cases Diagnosed in 2002-2003 by Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-144
NYS Adult HIV Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-145
NYC Adult HIV Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-146
NYS (excluding NYC) Adult HIV Cases Diagnosed in 2002-2003 By Race/Ethnicity, Age at Diagnosis, Gender, and Risk	2-147

AIDS Cases among Adults/Adolescents Ages 13-24 Diagnosed 2000-2003 by Age at Diagnosis and Transmission Category	2-148
Cumulative NYS AIDS Cases Among Adult Males Ages 25+ by Year of diagnosis and Race/Ethnicity	2-151
Cumulative NYS AIDS Cases Among Adult Females Ages 25+ by Year of diagnosis and Race/Ethnicity	2-153
NYS Persons 50+ Years of Age Living with HIV/AIDS by Gender, Race/Ethnicity, Age at Diagnosis, and Geographic Region	2-155
NYS AIDS Cases Diagnosed 2000-2003 Among Persons 50+ Years of Age by Gender, Race/Ethnicity, Age at Diagnosis, and Geographic Region	2-156
Persons Living with HIV/AIDS by Age, Transmission Category, and Race/ Ethnicity: NYC and Upstate NY	2-157
AIDS Cases Diagnoses During 2002 and 2003 per 100,000 Population by Race/ Ethnicity and Ryan White Region	2-159
Adults Living with HIV/AIDS by Race/ Ethnicity, Age at Diagnosis, Gender and Risk: NYS, NYC, and NYS (excluding NYC)	2-162
Pediatric AIDS Cases by Gender, Age at Diagnosis, Race/Ethnicity, and Mother's Transmission Risk – 2000-2003	2-165
Pediatric AIDS Cases Diagnosed 2000-2003 by Race/Ethnicity, Exposure Category, Age at Diagnosis, Rate per 100,000 Population and NYS Geographic Region	2-167
Perinatally-Infected Persons Living with HIV/AIDS by Race/Ethnicity, Gender, and New York State Region	2-168
Further Data Describing NYS	2-169
New York State and Counties as Compared to the District of Columbia and other States (A Ranking)	2-171
Counseling and Testing	2-179
AIDS as a Leading Cause of Death/AIDS Mortality	2-187

Volume 2

Table of Contents

Dedication	i
Acknowledgements	iii
Table of Contents	v
Introduction to the 2005-2006 Epidemiologic Profile	xiii
Visual Display of Racial/Ethnic Data: Data Availability Notice	xv

Continued from Volume I

Youth Risk Behavior Surveillance System YRBSS)	2-193
New HIV/AIDS Surveillance Activities	2-197
Statistical Abstract – 2003, Sexually Transmitted Disease Control Program, NYSDOH	2-199
Eliminating Syphilis -- New York	2-239
HIV Epidemiology Program: 1st Quarter 2006 Report New York City Department of Health and Mental Hygiene – Data through March 31, 2005	2-241
 Question 3: What are the indicators of risk for HIV infection and AIDS in New York State?	 3-1
Introduction	3-3
External Factors	3-5
Poverty	3-7
Trauma	3-11

Rural Life	3-13
Stigma	3-19
Key Populations of NYS	3-21
Men who have Sex with Men	3-23
Injection Drug Users	3-33
Heterosexuals	3-39
Mother-to-Child-Transmission: Pregnant Women and Newborn Children	3-43
Persons at Particular Risk	3-49
Introduction	3-51
Inmates	3-53
Individuals with One or More Disabilities	3-59
Mentally Ill Chemical Abusers (MICA)	3-67
Individuals who are Homeless	3-69
Housing: Top 10 Least Affordable States	3-72
What does it take to <i>not</i> be homeless?	3-72
Immigrants	3-73
Migrants and Seasonal Workers	3-75
Persons of Transgender Experience	3-79
Alcohol and Non-injection Drug Use	3-91
Drug and Alcohol Use and Perception of Risk of Abuse: Persons 12 Years of Age and Older	3-92
Young People	3-97
Direct and Indirect Marker of HIV Risk	3-99
The Importance of Certain Communicable Diseases when in Conjunction with HIV	3-101

Selected Communicable Diseases: A Brief Description	3-102
Primary and Secondary Syphilis, Gonorrhea, and Chlamydia	3-105
Selected Communicable Diseases of Concern in HIV/AIDS Prevention by NYS Geographical Region And County	3-111
Trends in Selected Communicable Diseases by Geographical Distribution	3-113
Tuberculosis in New York State	3-115
Cervical Cancer	3-119
Pregnancy-Related Data	3-125
Geographic Risk	3-127
Out-of-State Risk	3-127
Drug Transport Routes:	3-129 3-132/3
Commercial Sex Work	3-135

Appendices	a-1
Abbreviations and Acronyms	a-3
Key Data Sources	a-5
How to Read and Understand a Scientific or Epidemiologic Article	a-7
NYS HIV Prevention Planning Group Epidemiologic Manual	a-13
Contact and Ordering Information	a-27

Youth Risk Behavior Surveillance System (YRBSS)

New York State 2003

The YRBSS monitors essential health-risk behaviors that contribute to the leading causes of morbidity and mortality among young people. YRBSS is administered to students grades 9-12 annually, generally between February and December and may be conducted directly by CDC or by state, territorial, and local educators.

There are six behavior categories of interest. However, not all categories are administered each year and questions may be added or removed as behavior changes over time. These categories are:

- Tobacco use
- Alcohol and drug use
- Sexual behaviors which could lead to unintentional pregnancy, STDs, and/or HIV infection
- Unhealthy dietary practices
- Physical inactivity
- Unintentional injuries and violence

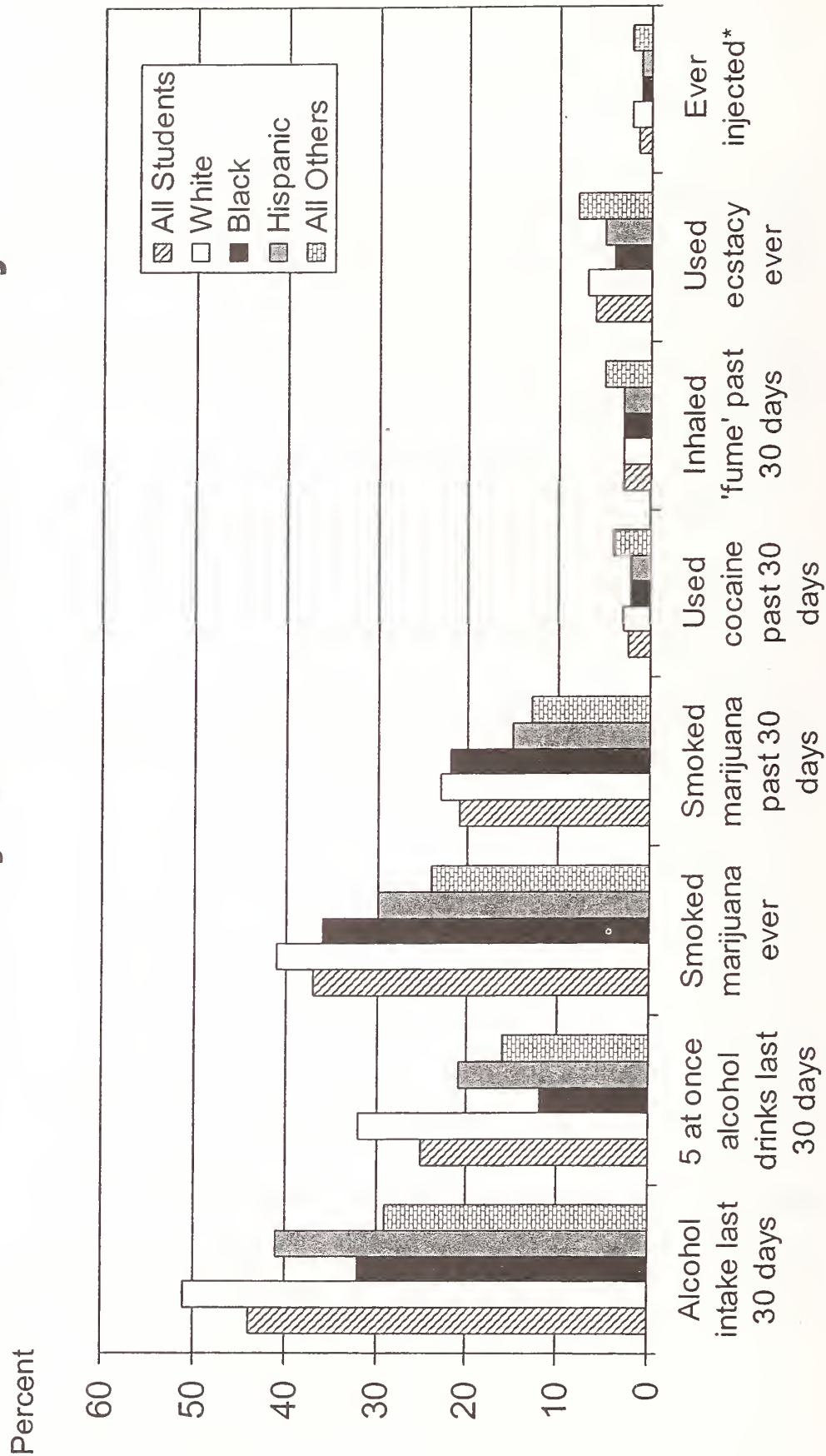
In the graphs that follow, only sexual behaviors, alcohol, and drug-related data are reported. The full report has been published by CDC as a MMWR Surveillance Summary and can be accessed at: www.cdc.gov

Reference:

Center for Disease Control and Prevention, *Youth Risk Behavior Surveillance ---- United States, 2003*. MMWR, Surveillance Summary, May 21, 2004 / Volume 53 / Number SS-2

YRBSS – New York State 2003

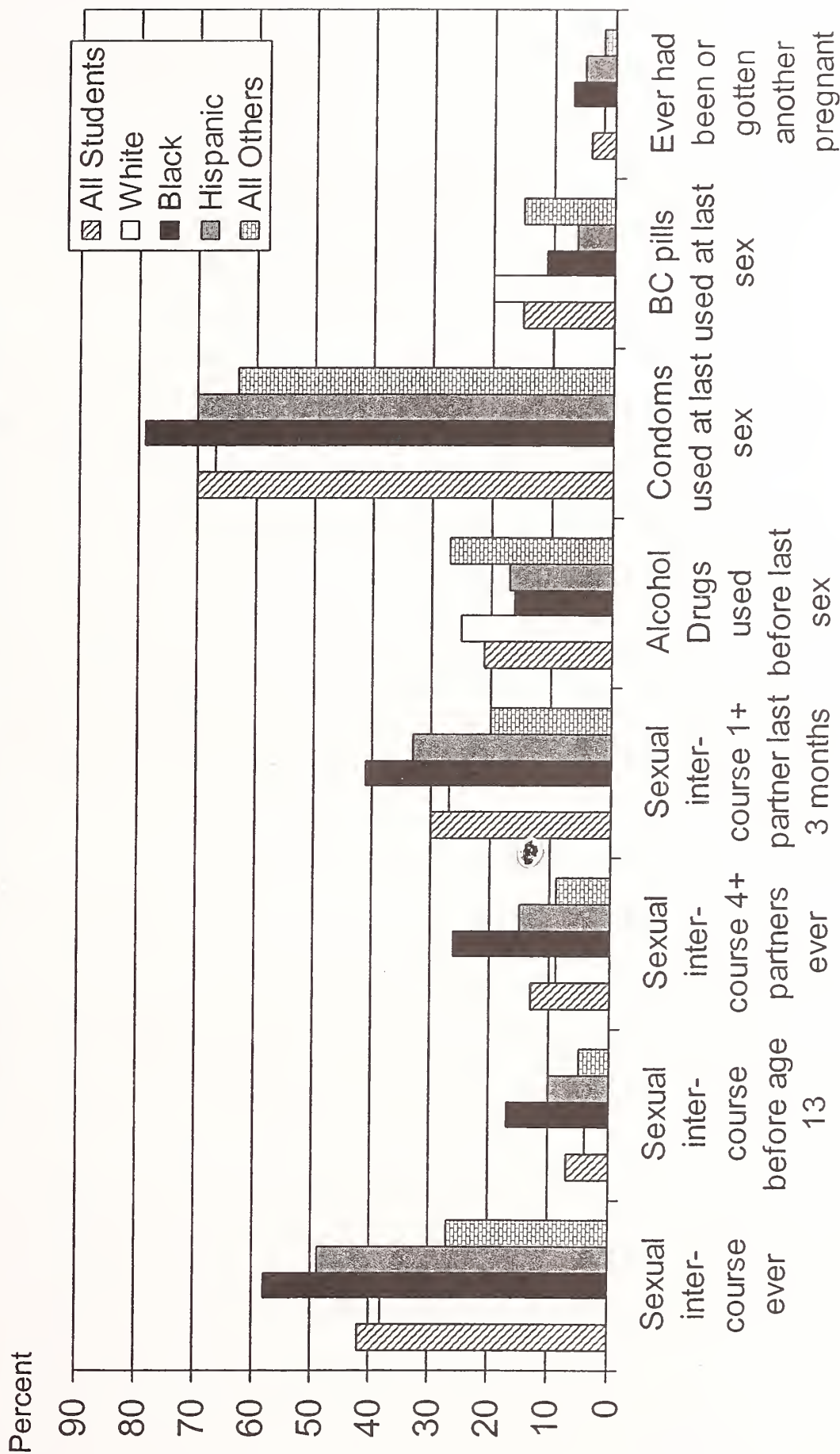
Percentage of Students Reporting an HIV Risk Behavior by Limited Race/Ethnicity



* Ever injected data is from YRBS 1999, the last year in which the question was asked in this format. All other data is YRBS 2003

YRBSS – New York State 2003

Percentage of Students Reporting an HIV Risk Behavior by Limited Race/Ethnicity



New HIV/AIDS Surveillance Activities

Throughout the NYSDOH various units initiate HIV/AIDS-related research projects as the epidemic shifts, as new scientific tools become available, and/or new insights emerge.

Two such projects are in the development stages at this time:

Acute HIV Infection Screening

A demonstration project to screen for acute HIV infection (AHI) among patients tested for HIV at the Monroe County Sexually Transmitted Diseases Clinic is currently getting under way. This project uses nucleic acid amplification testing (NAAT) to detect RNA in seronegative (blood that tested HIV-antibody negative) blood samples. It is modeled after the successful statewide implementation of a similar program in North Carolina. Once an AHI index case, a person with a negative HIV-antibody test *and* a positive NAAT test, has been identified, counseling and confirmatory testing will take place. Most importantly, active case finding among high-risk contacts will also occur. This means that it will be possible to prevent further transmission at a moment in which the acutely-infected individual's viral load is at its highest level and most likely to be transmitted to others. This process will also allow the STD Clinic staff to identify new HIV infections among partners and to bring them into prevention and care services.

HIV Incidence Surveillance

Since 2003, CDC and state health departments have been working to establish a national system of HIV Incidence Surveillance using laboratory testing known as STARHS (“Serologic Testing Algorithm for Recent HIV Seroconversion”). The incidence of HIV infection refers to the number of individuals recently infected and diagnosed with HIV. Knowledge of where and how recent HIV infections are occurring will give valuable guidance to HIV prevention activities.

From June 2004 through June 2005, NYS implemented HIV Incidence Surveillance in the NYSDOH Anonymous Counseling and Testing Clinics under a research protocol requiring patient consent. Due to a change in the laboratory test used in STARHS, the FDA regulatory structure began to permit HIV incidence surveillance to be incorporated into routine HIV/AIDS surveillance in the spring of 2005. As of July 2005, the NYSDOH is working to implement incidence surveillance statewide.

SEXUALLY TRANSMITTED DISEASE CONTROL PROGRAM

New York State Department of Health

STATISTICAL ABSTRACT

2003

The rate of reported syphilis infections in New York State rose by 30 percent in 2003, marking the third successive year of substantial increases, and denoting a distinct reversal of a downward trend commenced in 1993. Reports of early syphilis (under one year's duration) had risen slightly in 1999 then dropped back in 2000, but the past three years have each witnessed increases in excess of 25 percent over the prior year. In New York City, the incidence of 1,482 cases translates to an infection rate of 18.5/100,000; the 114 cases outside New York City are the equivalent of 1 infection for every 100,000 residents. Congenital syphilis cases statewide numbered 52 in 2002 (32 in New York City and 20 elsewhere in the State), a sharp increase from the 30 cases reported the previous year, and a significant departure from a general downward trend, begun in 1991. All of New York City's congenital syphilis reports were among infants; five of the cases reported outside the City were post infancy. Three were stillbirths, and one was aged 28. Thirteen of the 20 cases (65 percent) occurred among adoptees or infants whose mothers recently immigrated to the United States.

Although total gonorrhea infections increased by only 24 cases from those reported the previous year, in New York City cases rose by 5 percent (from 12,811 to 13,484), while in the rest of the State cases declined by 7 percent (from 9,117 to 8,484). The 21,952 cases reported in 2003, however, measure less than a quarter of the peak incidence established in 1986. Reports from the Buffalo area declined 17.3 percent, followed by decreases in the Albany (9.2 percent), Syracuse (11.5 percent) and Metropolitan (3.2 percent) areas. Only the Rochester area experienced an increase (6.9 percent). Following a decade-long pattern, case rates for females aged 15-19 continued to be the highest for any of the five-year age groups, followed by females aged 20-24 and males aged 20-24.

This document contains data for the third full-year's statewide reporting of *Chlamydia trachomatis* infection (CTI, commenced August 30, 2000). Of the total 56,633 cases, 61.4 percent were reported in New York City, where reports increased by 4.5 percent above 2002. In the rest of the State, the number of reports increased by 20.8 percent. In the Rochester area, reporting soared by 62.3 percent; the Albany, Buffalo, Syracuse and Metropolitan areas registered increases of 4.3 percent, 4.9 percent, 20.7 percent and 18.9 percent, respectively. The CTI age-gender incidence curve resembles that for gonorrhea insofar as the peak burdens fall on teens and young adults, but in contrast to a nearly equal sex ratio for gonorrhea cases, about three of every four reported *C. trachomatis* infections is in a female. Moreover, the incidence among females aged 15-24 is well over four times that of gonorrhea, while overall about two and a half times as many cases of CTI are reported. Further detail may be found in Tables II, V- VIII. Data shown in Tables IX and X (Demographic Characteristics of Those Screened for Chlamydial Infection) are gathered from clinics in which testing is funded by the Bureau of STD Control. In Sentinel Sites, all patients are screened for *Chlamydia* regardless of age or sex. Prevalence Sites generally adhere to age-based testing criteria: in Title X clinics (e.g. family planning clinics), all women ≤ 24 years of age are screened at initial or annual visit, and in STD clinics, all women ≤ 29 years of age. These programs are narrowly targeted because the most serious complications of CTI; pregnancy loss, infertility, and newborn infections, occur most frequently among asymptomatic young females.

Under the Public Health Law, each county is responsible for the control and reporting of communicable disease. The New York State Department of Health works closely with the counties to ensure that the control methods utilized are effectively maintained and that the quality of services is acceptable. Since each county's program must contend with different patterns of morbidity, staffing and clinical services, interpretation of the data contained herein must be performed with an appreciation of such local differences. While this report provides a quick statistical reference for the year's surveillance activities, more detailed information can be obtained from the New York State Department of Health Bureau of STD Control, Corning Tower, Room 1168, Albany, New York, 12237-0670 (518 474-3598).

STD Control Program

Statistical Abstract 2003

<u>TABLE</u>	<u>PAGE</u>
I. Reported Cases of Early Syphilis and Gonorrhea, and Rates per 100,000; United States, New York City, and New York State exclusive of New York City; 1982 - 2003	1
II. Syphilis, Gonorrhea, and Chlamydia, Cases and Rates per 100,000, County and Health Area - 2003	8-10
III. Reported Cases of Early Syphilis, County, Area, Age, and Sex, 2003	14-15
IV. Reported Cases of Gonorrhea, County, Area, Age, and Sex, 2003	16-18
V. Reported Cases of Chlamydia, County, Area, Age, and Sex, 2003	19-21
VI. Reported Syphilis, by Stage, Gonorrhea, and Chlamydia; Cases and Rates per 100,000 for Urban and Other Populations, 2003	22
VII.A Reported Cases of Syphilis, Gonorrhea, and Chlamydia - 2003; Patient Age Group and Gender; New York State exclusive of New York City	23
VII.B Case Rates per 100,000 for Reported Cases of Syphilis, Gonorrhea, and Chlamydia - 2003; Patient Age Group and Gender; New York State exclusive of New York City	24
VIII. A Reported Cases of Syphilis, Gonorrhea, and Chlamydia - 2003; Patient Age Group and Gender; New York City	25
VIII. B Case Rates per 100,000 for Reported Cases of Syphilis, Gonorrhea, and Chlamydia - 2003; Patient Age Group and Gender; New York City	26
IX. Demographic Characteristics of Females Screened for Chlamydial Infection in Sentinel Sites - 2003	35
X. Screening for Chlamydial Infection in Prevalence Monitoring Sites - 2003	36

<u>FIGURE</u>	<u>PAGE</u>	
I A.	Reported Cases of Early Syphilis, New York State, 1981 - 2003	2
I B.	Reported Cases of Early Syphilis, New York State exclusive of New York City, 1981 - 2003	3
I C.	Reported Cases of Early Syphilis, New York City, 1981 - 2003	4
II A.	Reported Cases of Gonorrhea, New York State, 1981 - 2003	5
II B.	Reported Cases of Gonorrhea, New York State exclusive of New York City, 1981 - 2003	6
II C.	Reported Cases of Gonorrhea, New York City, 1981 - 2003	7
III.	Case Rates for Early Syphilis (Semilogarithmic scale), 1981 - 2003	11
IV A.	Early Syphilis, New York State exclusive of New York City, 1988 - 2003	12
IV B.	Early Syphilis, New York City, 1988 - 2003	13
V.	Age, Gender-specific Incidence Rates, Early Syphilis, 2003	27
VI.	Age, Gender-specific Incidence Rates Gonorrhea, 2003	28
VII.	Age, Gender-specific Incidence Rates, Chlamydia, 2003	29
VIII.	Early Syphilis, Case Rates per 100,000, 2003 (Map)	30
IX.	Gonorrhea, Case Rates per 100,000, 2003 (Map)	31
X.	Chlamydia, Case Rates per 100,000, 2003 (Map)	32
XI.	Reported Cases of Congenital Syphilis in Infants, 2003 (Map)	33
XII.	Reported Cases of Congenital Syphilis in Infants, 1983 - 2003	34

Case rates for New York State counties and for age groupings are based on United States Bureau of the Census data for April 1, 2000, provided by GeoLytics, Inc.

*Morbidity and case rates for the **United States** (Table I) are courtesy of the Centers for Disease Control and Prevention, Division of STD/HIV Prevention, Statistical Services Section. Data for **New York City** (Tables II-VIII, Figures II-IX) are courtesy of the New York City Bureau of Sexually Transmitted Disease Control, New York City Department of Health and Mental Hygiene, 125 Worth Street, Room 207, New York, NY 10013.*

Reported Cases of Early Syphilis and Gonorrhea; Rates per 100,000
United States, New York City, and New York State exclusive of New York City
1982 - 2003

Year	PRIMARY, SECONDARY SYPHILIS						EARLY LATENT SYPHILIS						GONORRHEA ^{a/}					
	United States			NY City			United States			NY City			United States			NY City		
	Cases	Rate	Upstate NY	Cases	Rate	Upstate NY	Cases	Rate	Upstate NY	Cases	Rate	Upstate NY	Cases	Rate	Upstate NY	Cases	Rate	Upstate NY
1982	33,613	14.6	2,580	37.1	479	4.6	21,894	9.5	1,903	27.4	380	3.6	960.6	417.9	48.21	694.2	20.71	198.4
1983	32,698	14.1	2,459	35.6	420	4.0	23,738	10.2	1,881	27.3	326	3.1	900.4	387.6	46.41	672.8	19.42	186.0
1984	28,607	12.2	2,280	32.5	338	3.2	23,132	9.9	1,906	27.2	270	2.6	878.6	374.8	48.54	692.2	18.88	181.2
1985	27,131	11.4	2,169	30.3	362	3.5	21,689	9.1	2,305	32.2	284	2.7	911.4	381.8	65.51	914.8	18.34	176.1
1986	27,667	11.5	2,112	29.2	285	2.7	21,656	9.0	2,005	27.7	205	1.9	892.2	370.1	76.40	1055.2	19.25	182.9
1987	35,585	14.8	4,542	62.1	368	3.5	28,233	11.7	3,501	47.9	248	2.4	801.7	329.4	66.54	909.9	17.71	168.1
1988	40,474	16.5	5,042	68.4	646	6.1	35,968	14.6	4,515	61.3	546	5.2	738.2	300.3	54.10	722.8	17.80	168.7
1989	45,826	18.5	4,362	59.2	1,022	9.7	45,394	18.3	5,847	79.4	939	8.9	734.5	295.7	40.55	550.5	17.43	165.3
1990	50,233	20.1	4,265	57.8	1,048	9.9	55,138	22.1	7,485	101.5	1,199	11.3	690.3	276.6	34.99	474.4	16.10	152.3
1991	42,950	17.0	3,133	42.8	692	6.5	53,855	21.4	6,769	92.4	892	8.4	623.0	247.1	28.94	395.3	14.59	136.7
1992	33,962	13.3	2,246	30.7	350	3.3	49,903	19.6	5,373	73.4	740	6.9	501.7	196.8	21.71	296.5	12.01	112.6
1993	26,497	10.3	1,129	15.3	258	2.4	41,902	16.3	3,747	50.8	509	4.7	443.3	172.0	18.47	250.5	10.88	100.9
1994	20,627	7.9	626	8.4	175	1.6	32,012	12.3	2,360	31.7	320	3.0	418.1	165.1	19.25	258.6	11.54	106.4
1995	16,542	6.3	362	4.8	85	0.8	26,655	10.1	1,944	26.0	157	1.4	392.6	149.4	16.36	218.8	9.61	88.3
1996	11,387	4.3	138	1.8	76	0.7	20,187	7.7	1,077	14.4	125	1.2	325.9	124.0	13.53	181.4	7.61	69.9
1997	8,556	3.2	97	1.3	41	0.4	16,631	6.2	666	8.8	93	0.8	327.6	122.4	14.56	193.0	6.80	62.4
1998	7,007	2.6	81	1.1	37	0.3	12,696	4.7	644	8.5	35	0.3	356.5	131.9	12.10	159.7	7.40	67.3
1999	6,617	2.4	130	1.7	20	0.2	11,534	4.2	659	8.7	41	0.4	360.8	132.3	12.21	161.1	7.66	69.5
2000	5,979	2.1	117	1.5	15	0.1	9,465	3.4	447	5.6	20	0.2	363.1	129.0	11.67	145.6	8.44	77.0
2001	6,103	2.2	282	3.8	22	0.2	8,701	3.1	548	7.4	18	0.2	361.7	128.5	12.61	169.4	9.69	89.9
2002	6,862	2.4	434	5.8	45	0.4	8,429	3.0	727	9.8	26	0.2	351.9	125.0	12.81	172.0	9.12	84.6
2003	7,177	2.5	531	6.6	53	0.5	8,361	2.9	951	11.9	61	0.6	335.1	116.2	13.47	168.2	8.48	77.4

^{a/} Thousands of cases

Figure I A

REPORTED CASES OF EARLY SYPHILIS New York State

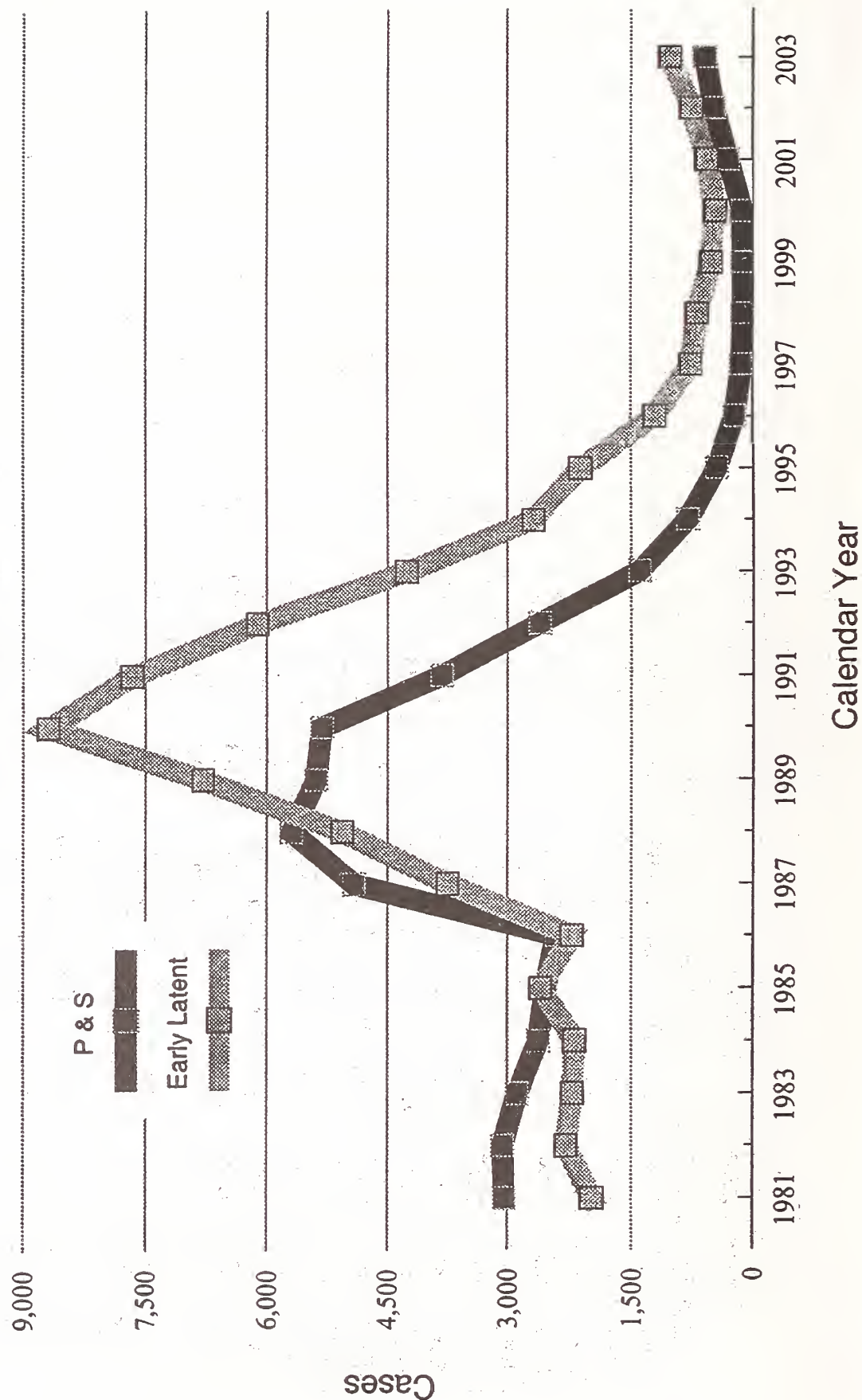


Figure I B

**REPORTED CASES OF
EARLY SYPHILIS**
New York State Exclusive of New York City

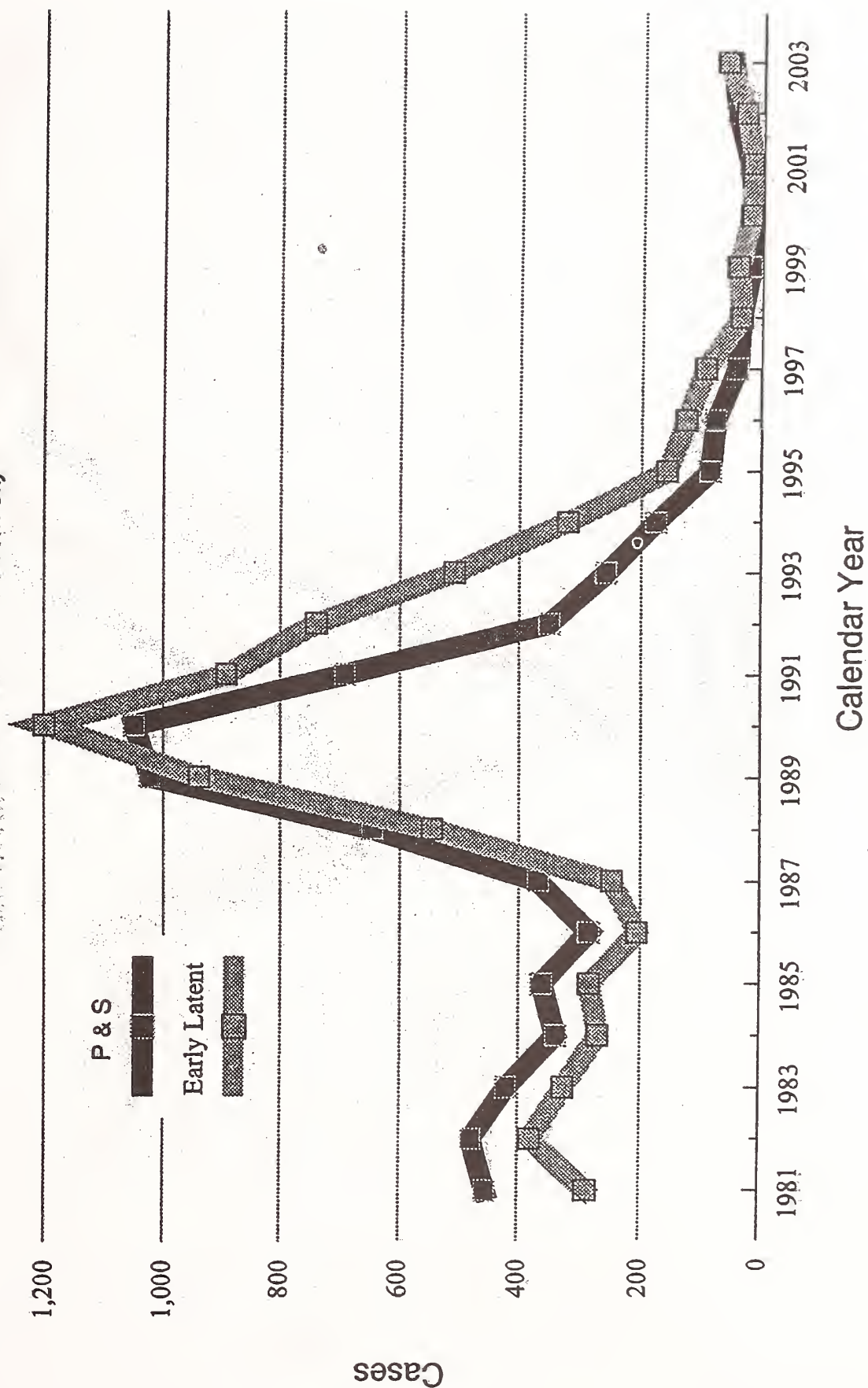


Figure 1C

REPORTED CASES OF EARLY SYPHILIS *New York City*

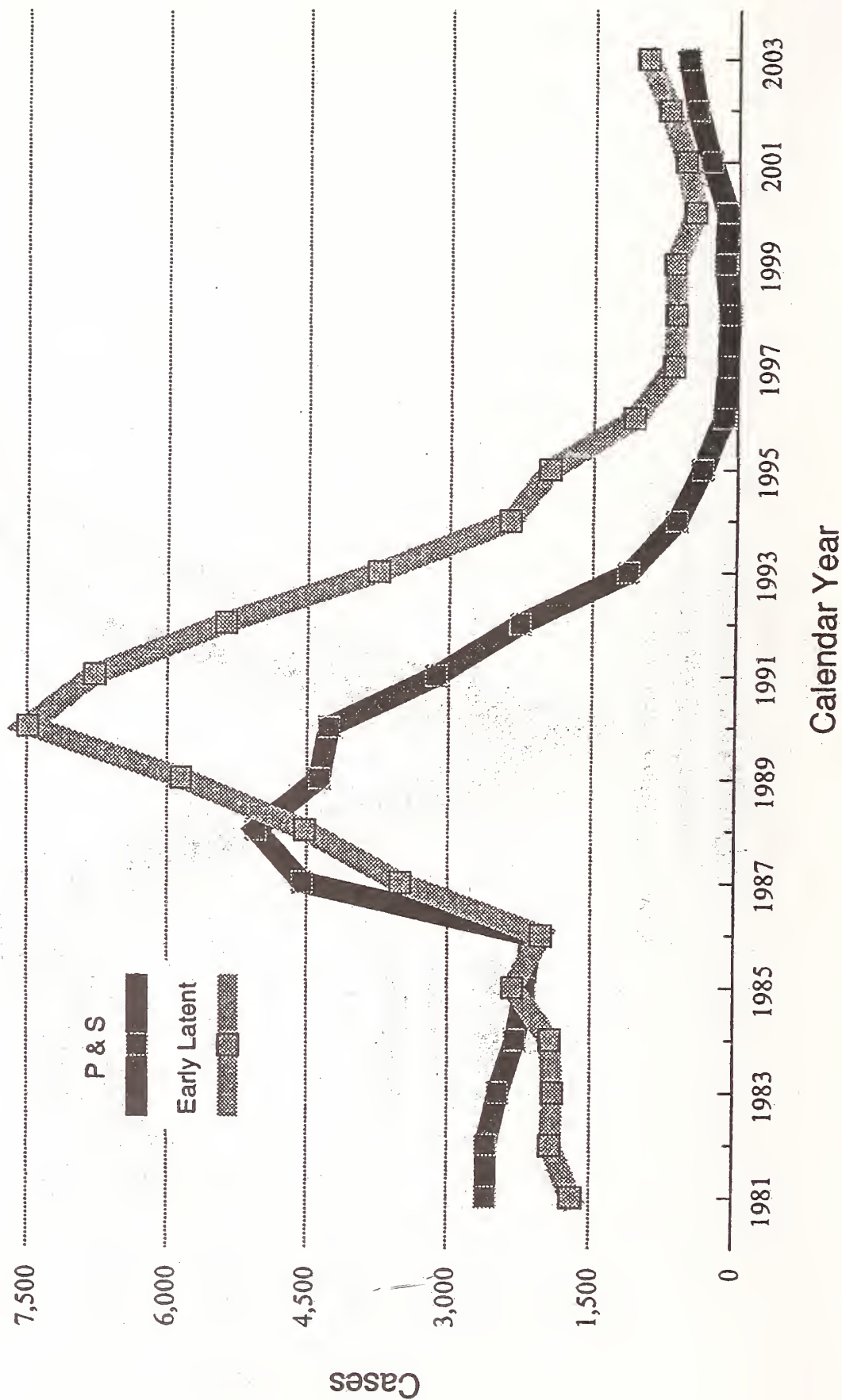


Figure II A

REPORTED CASES OF GONORRHEA

New York State

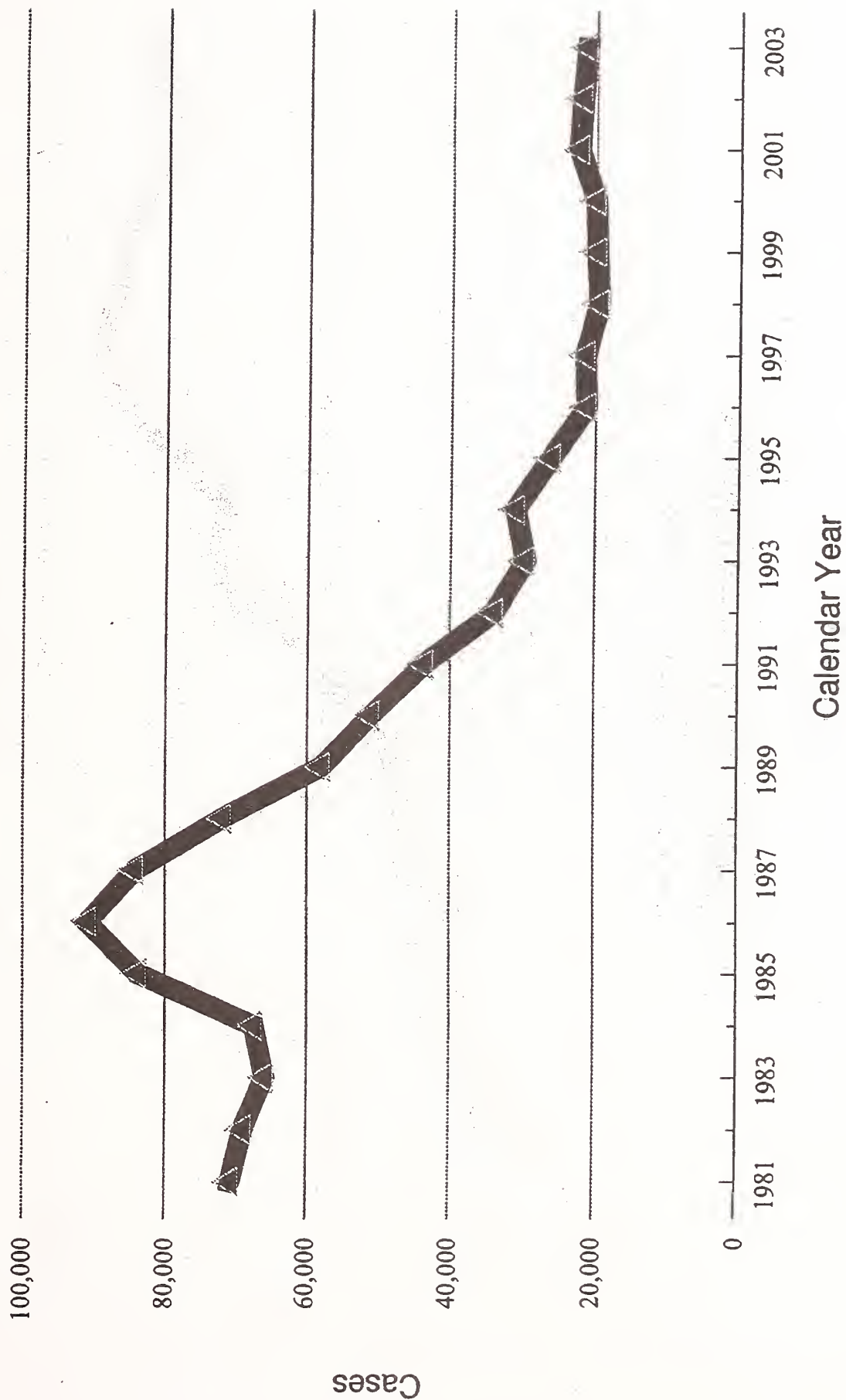


Figure II B

REPORTED CASES OF GONORRHEA

New York State Exclusive of New York City

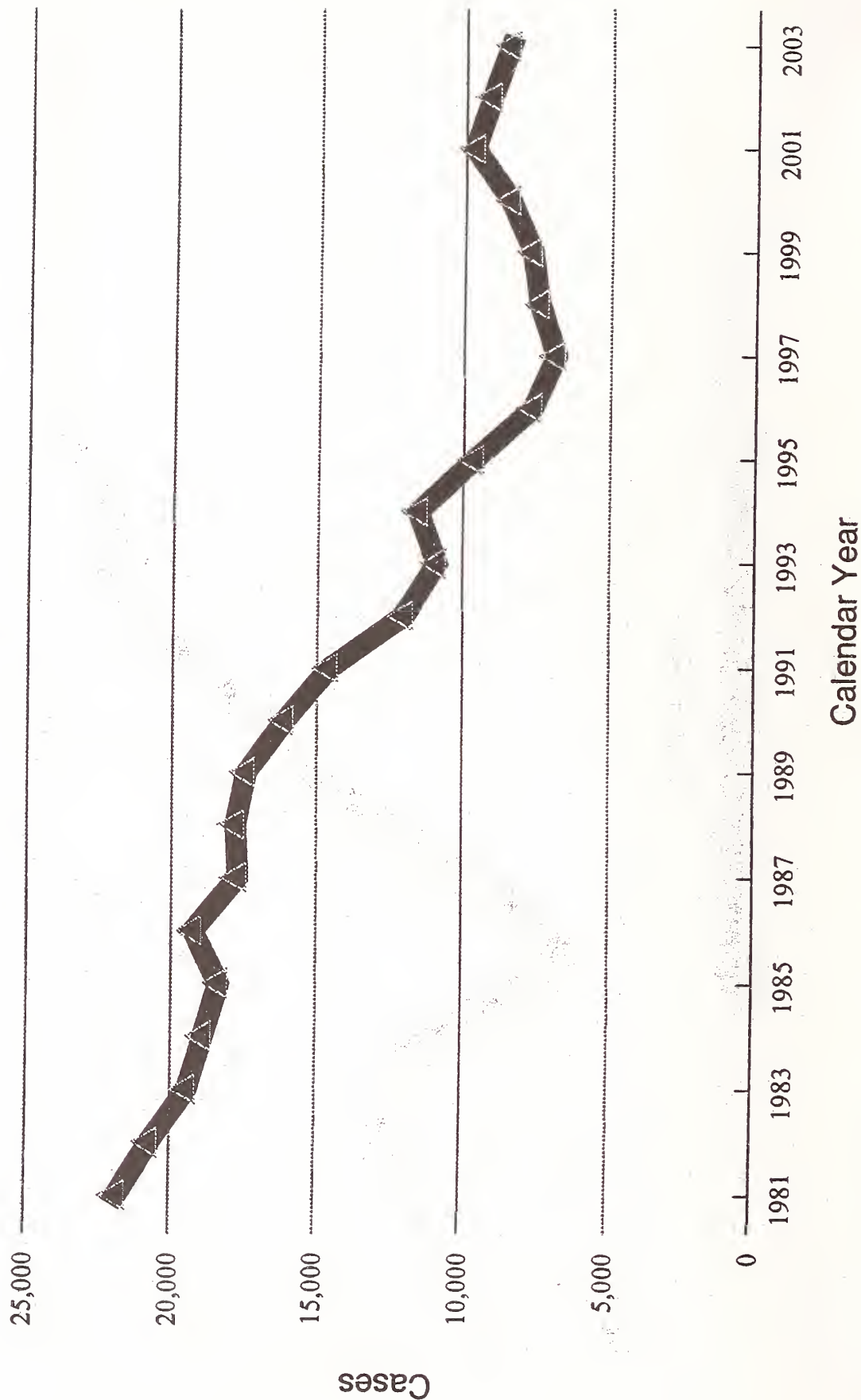


Figure II C

REPORTED CASES OF GONORRHEA

New York City

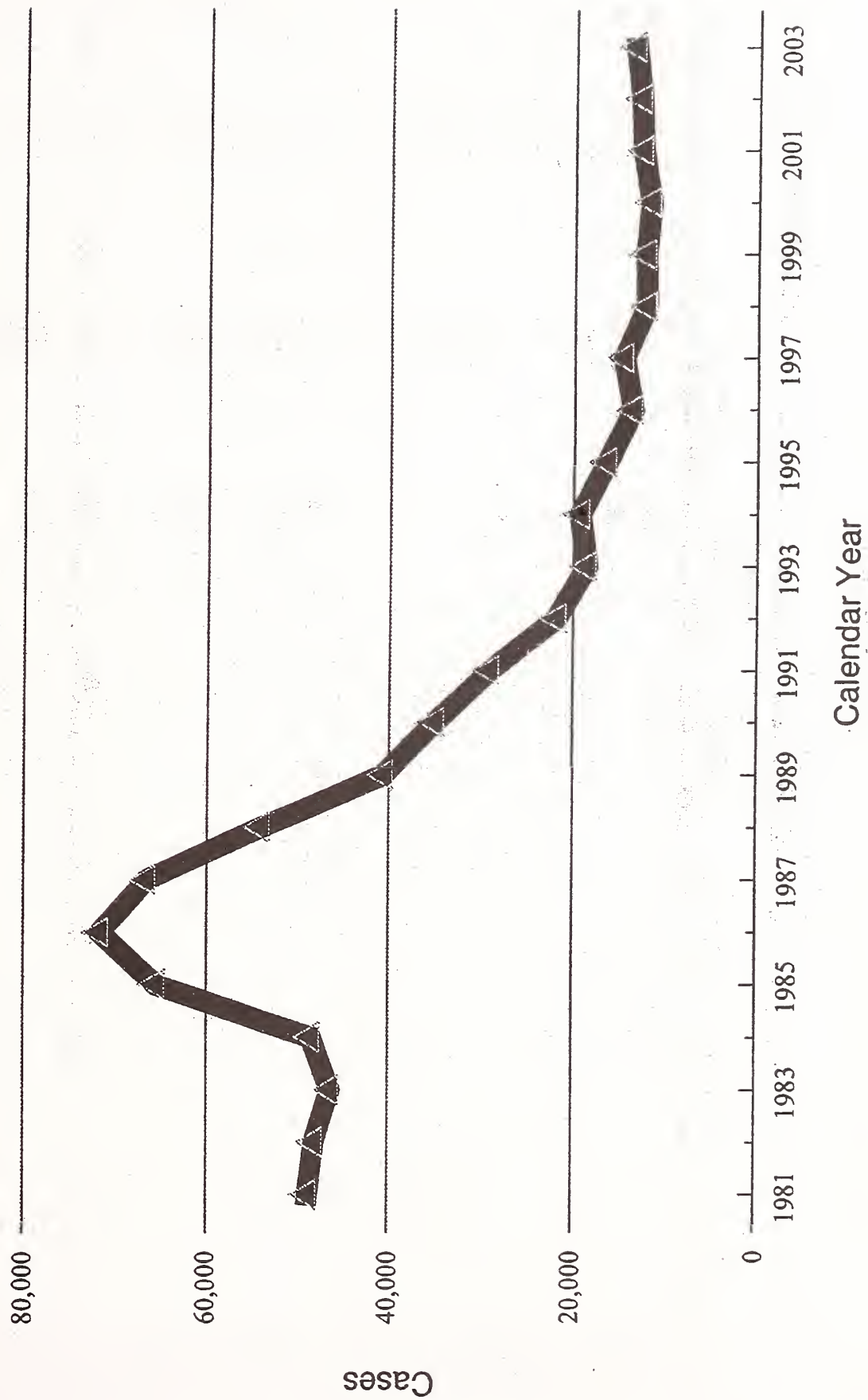


TABLE II

Syphilis, Gonorrhea, and Chlamydia - Cases and Rates per 100,000, County and Health Area - 2003

SYPHILIS														GONORRHEA		CHLAMYDIA	
County	Primary		Secondary		Early Latent		Total Early		Late and Latent		Total		Cases	Rate			
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate					
Albany			1	0.34			1	0.34	3	1.02	4	1.36	511	173.5	920	312.3	
Clinton									1	1.25	1	1.25	29	36.3	135	169.0	
Columbia	1	1.58					1	1.58			1	1.58	31	49.1	79	125.2	
Delaware													3	6.2	35	72.8	
Essex													2	5.1	27	69.5	
Franklin									1	2.07	1	2.07	4	8.3	51	99.7	
Fulton	1	1.82					1	1.82			1	1.82	8	14.5	103	187.0	
Greene	1	2.07					1	2.07			1	2.07	4	8.3	45	93.4	
Hamilton															2	37.2	
Montgomery									1	2.01	1	2.01	6	12.1	48	96.6	
Otsego													6	9.7	74	120.0	
Rensselaer	1	0.66			1	0.66	2	1.31	2	1.31	4	2.62	127	83.3	279	182.9	
Saratoga									1	0.50	1	0.50	37	18.4	210	104.7	
Schenectady	1	0.70					1	0.68			1	0.68	183	124.9	462	315.2	
Schoharie													3	9.5	28	88.7	
Warren									2	3.28	2	3.28	8	12.6	69	109.0	
Washington													5	8.2	53	86.8	
ALBANY AREA TOTAL	5	0.34	1	0.07	1		7	0.48	11	0.76	18	1.24	967	66.6	2,620	180.5	
Allegany									1	2.00	1	2.00	3	6.0	61	122.2	
Cattaraugus			1	1.19			1	1.19			1	1.19	7	8.3	39	46.5	
Chautauqua									6	4.29	6	4.29	61	43.6	277	198.2	
Erie			2	0.21	2	0.21	4	0.42	7	0.74	11	1.16	1,572	165.4	2,985	314.1	
Genesee													14	23.2	46	76.2	
Niagara													237	107.8	528	240.2	
Orleans													15	34.0	73	165.3	
Wyoming															23	53.0	
BUFFALO AREA TOTAL			3	0.19	2	0.13	5	0.31	14	0.88	19	1.19	1,909	119.9	4,032	253.3	

TABLE II (Continued)

Syphilis, Gonorrhea, and Chlamydia - Cases and Rates per 100,000, County and Health Area - 2003

County	SYPHILIS										GONORRHEA		CHLAMYDIA	
	Primary		Secondary		Early Latent		Total Early		Late and Late Latent		Total			
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Chemung					1	1.10			1	1.10	1	1.10	131	143.8
Livingston					1	1.55			1	1.55	1	1.55	6	9.3
Monroe	7	0.95	8	1.09	15	2.04			14	1.90	29	3.94	1,820	247.5
Ontario					1	1.00			1	1.00	1	1.00	20	20.0
Schuyler					1	5.20			1	5.20	1	5.20	5	26.0
Seneca					1	3.00			1	3.00	1	3.00	3	9.0
Steuben					2	2.03			2	2.03	2	2.03	20	20.3
Wayne					2	2.13			2	2.13	2	2.13	36	38.4
Yates					1	4.06			1	4.06	1	4.06	2	8.1
ROCHESTER														
AREA TOTAL	7	0.56	8	0.63	15	1.19	24	1.90	39	3.09	2,043	162.1	4,451	353.1
Broome	1	0.50			4	1.99	5	2.49	19	9.47	24	11.97	99	49.4
Cayuga													27	32.9
Chenango													2	3.9
Cortland													10	20.6
Herkimer													12	18.6
Jefferson													59	52.8
Lewis													2	7.4
Madison													11	15.8
Oneida	3	1.27	1	0.42	2	0.85	6	2.55	3	1.27	9	3.82	245	104.0
Onondaga					1	0.22	1	0.22	14	3.05	15	3.27	1,001	218.4
Oswego													8	6.5
St Lawrence									2	1.79	2	1.79	11	9.8
Tioga													4	7.7
Tompkins	1	1.04			1	1.04			2	2.07	3	3.11	15	15.5
SYRACUSE														
AREA TOTAL	5	0.29	1	0.06	7	0.40	13	0.75	40	2.31	53	3.06	1,506	87.0
													4,190	242.0

TABLE II (Continued)

Syphilis, Gonorrhea, and Chlamydia - Cases and Rates per 100,000, County and Health Area - 2003

County	SYPHILIS										GONORRHEA		CHLAMYDIA	
	Primary		Secondary		Early Latent		Total Early		Late and Latent		Total			
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
Dutchess					4	1.43	4	1.43	19	6.78	23	8.21	207	73.9
Nassau	3	0.22	8	0.60	5	0.37	16	1.20	94	7.04	110	8.24	440	33.0
Orange	1	0.29			1	0.29	2	0.59	10	2.93	12	3.52	150	43.9
Putnam			2	2.09	1	1.04	3	3.13	2	2.09	5	5.22	10	10.4
Rockland	1	0.35			3	1.05	4	1.39	38	13.25	42	14.65	57	19.9
Suffolk	4	0.28	4	0.28	13	0.92	21	1.48	67	4.72	88	6.20	470	33.1
Sullivan					2	2.70	2	2.70	5	6.76	7	9.46	35	47.3
Ulster	1	0.56	1	0.56	1	0.56	3	1.69	11	6.19	14	7.88	99	55.7
Westchester	2	0.22	4	0.43	13	1.41	19	2.06	74	8.01	93	10.07	591	64.0
METRO NY														
AREA TOTAL	12	0.24	19	0.39	43	0.87	74	1.50	320	6.49	394	7.99	2,059	41.7
UPSTATE														
TOTAL	22	0.20	31	0.28	61	0.56	114	1.04	409	3.73	523	4.77	8,484	77.4
NEW YORK														
CITY	150	1.87	381	4.76	951	11.88	1,482	18.51	2,301	28.73	3,783	47.24	13,468	168.2
TOTAL														
STATE	172	0.91	412	2.17	1,012	5.33	1,596	8.41	2,710	14.28	4,306	22.69	21,952	115.7
													56,633	298.4

Figure III

CASE RATES FOR EARLY SYPHILIS

(Semilogarithmic Scale)

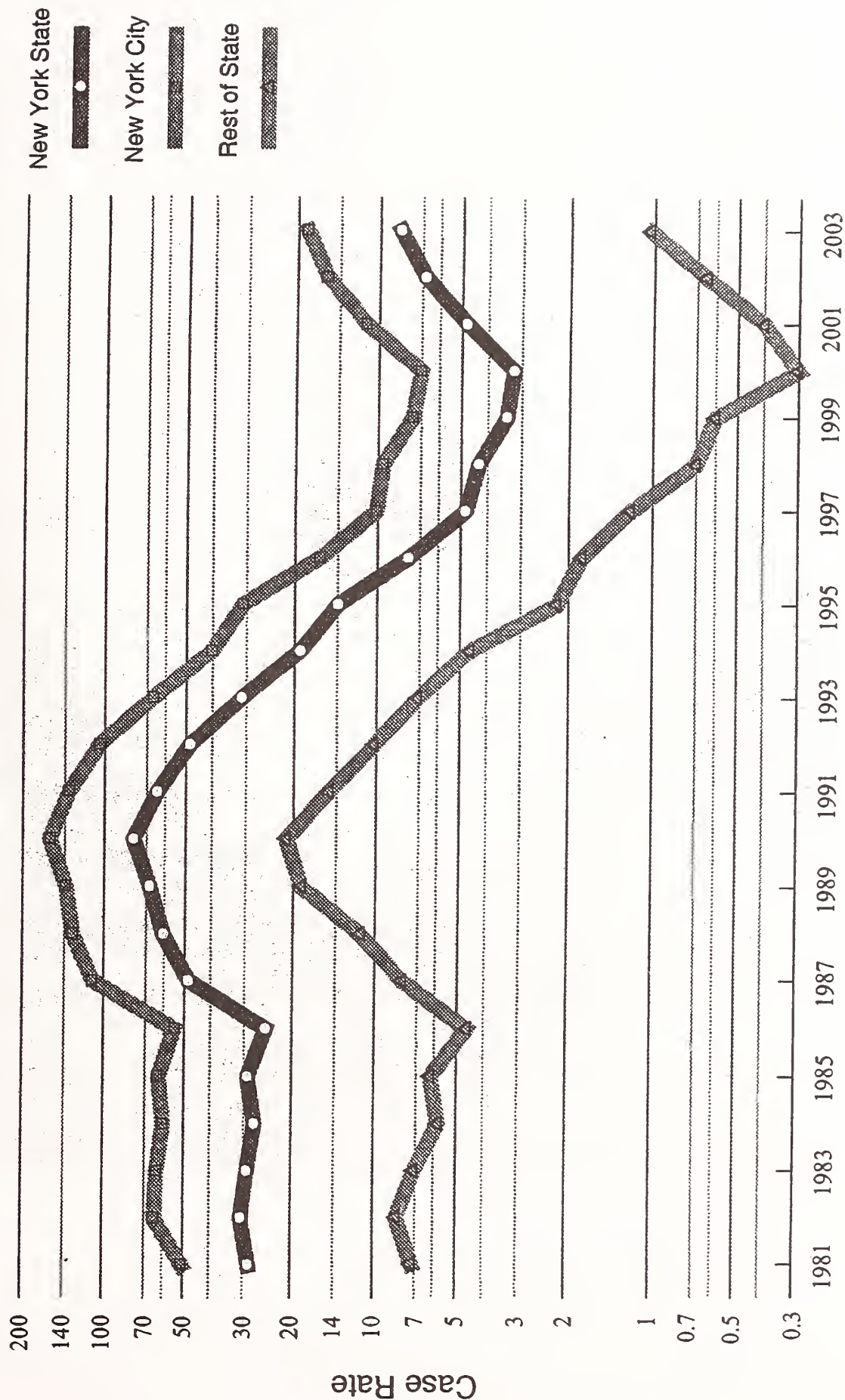


Figure IVA

EARLY SYPHILIS

1988 - 2003

New York State exclusive of New York City

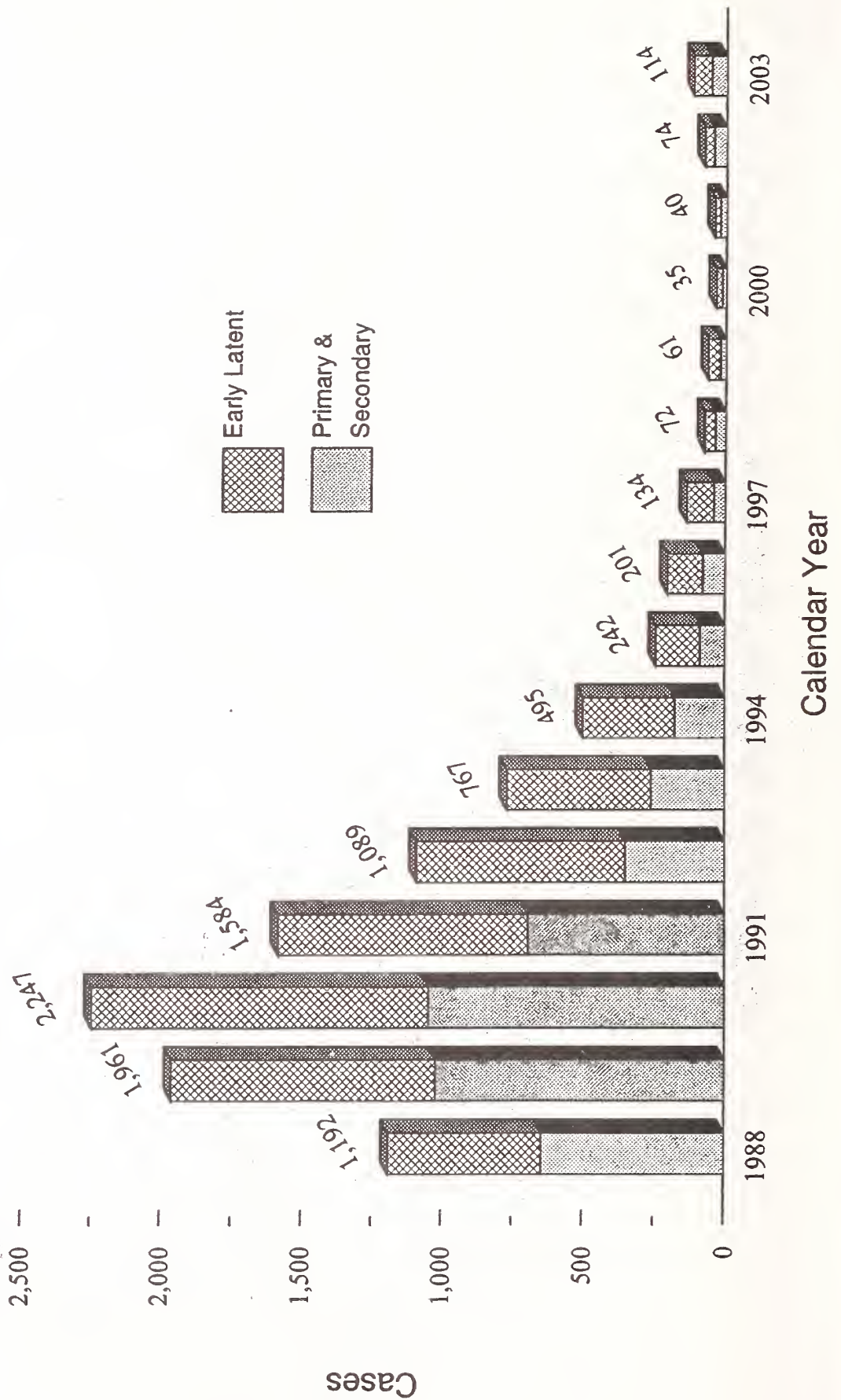


Figure IV B

EARLY SYPHILIS

New York City

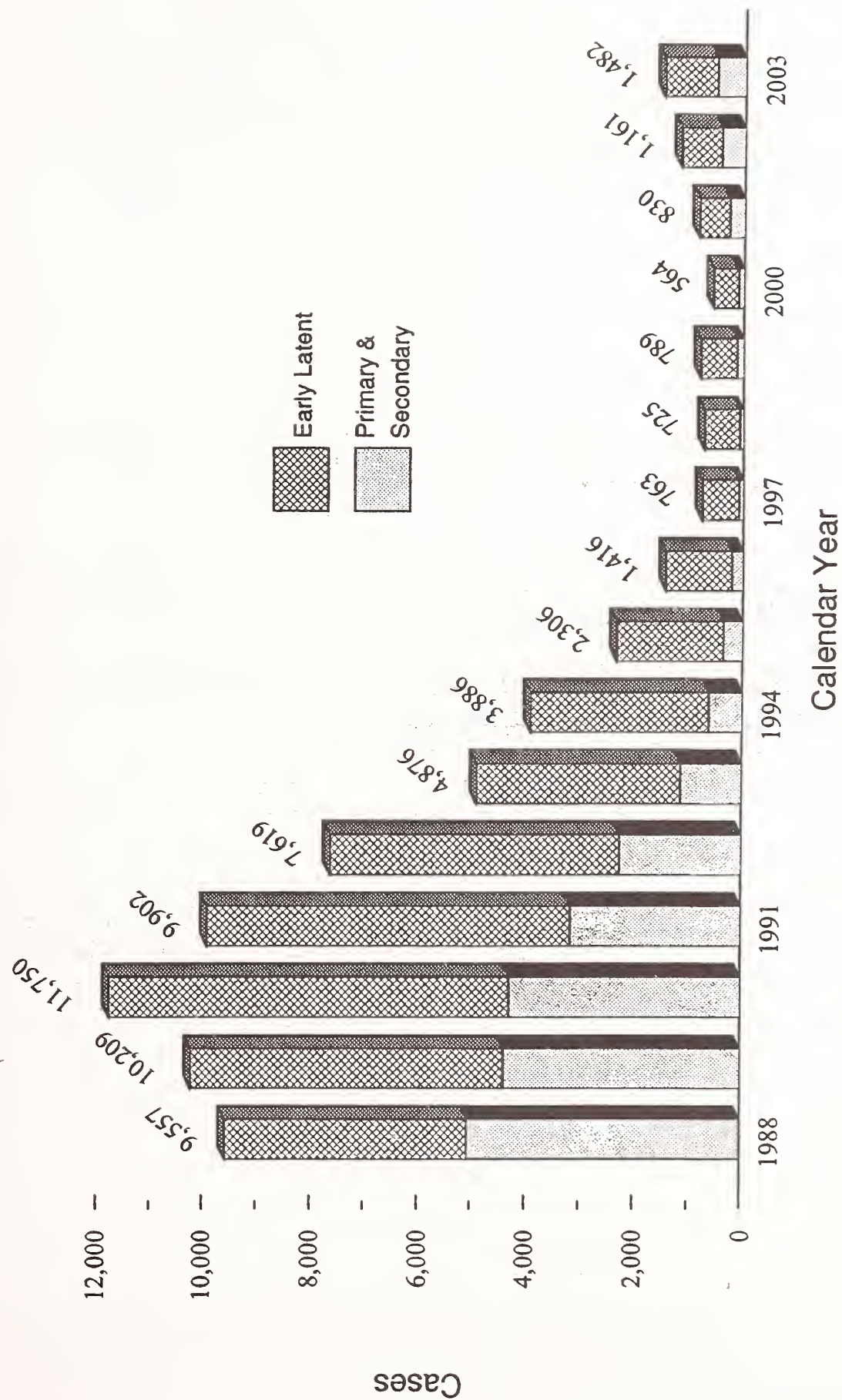


TABLE III
Reported Cases of Early Syphilis*
County, Area, Age, and Gender

2003

County	Age Gender	15-19		20-24		25-29		30-39		40+		Total		TOTAL
		M	F	M	F	M	F	M	F	M	F	M	F	
Albany								1				1		1
Columbia				1								1		1
Fulton										1		1		1
Greene										1		1		1
Rensselaer							1	1				1	1	2
Schenectady										1		1		1
ALBANY AREA TOTAL				1			1	2		3		6	1	7
Cattaraugus										1		1		1
Erie				1		1	2					2	2	4
BUFFALO AREA TOTAL				1		1	2			1		3	2	5
Monroe				1	1		1	3	2	7		11	4	15
ROCHESTER AREA TOTAL				1	1		1	3	2	7		11	4	15
Broome			1				1	3				3	2	5
Oneida					1				1	3	1	3	3	6
Onondaga										1		1		1
Tompkins								1				1		1
SYRACUSE AREA TOTAL			1		1		1	4	1	4	1	8	5	13
Dutchess					1	1			1	1		2	2	4
Nassau				3				8	1	4		15	1	16
Orange		1					1					1	1	2
Putnam						1		1		1		3		3
Rockland				2		1	1					3	1	4
Suffolk		1		5		1	2	6		6		19	2	21
Sullivan							1	1				1	1	2
Ulster			1					2				2	1	3
Westchester			1	2		1		8	1	6		17	2	19
METRO NEW YORK AREA TOTAL		2	2	12	1	5	5	26	3	18		63	11	74
TOTAL		2	3	15	3	6	10	35	6	33	1	91	23	114

TABLE III (Continued)

Reported Cases of Early Syphilis*
County, Area, Age, and Gender

2003

<u>Age Group</u>	<u>Male</u>	<u>Female</u>	<u>Total</u>
10 - 14	2	1	3
15 - 19	32	22	54
20 - 24	105	33	138
25 - 29	162	25	187
30 - 34	265	28	293
35 - 39	291	28	319
40 +	426	62	488
TOTAL	1,283	199	1,482

* Under one year's duration

TABLE IV
Reported Cases of Gonorrhea
County, Area, Age, and Gender

2003

County Gender	Age		0 - 9		10 - 14		15-19		20-24		25-29		30-39		40+		Total*		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
Albany			1	6			51	90	77	70	49	26	73	25	29	13	281	230	511
Clinton				1				4	3	10	3	5	2	1			8	21	29
Columbia				1			2	6	5	6	1	5	4	1			12	19	31
Delaware							1	1							1		2	1	3
Essex								2											2
Franklin				1				3											4
Fulton								2				1					2	6	8
Greene							1	1		1	1						2	2	4
Montgomery								1	1		3		1				5	1	6
Otsego							1	2		1			1				2	4	6
Rensselaer	2						3	32	22	22	11	11	10	7	6	1	52	75	127
Saratoga				1			2	9	4	8	5	1	3	2	2		16	21	37
Schenectady			1	1			10	32	29	36	16	10	22	14	9	3	87	96	183
Schoharie							1	1		1							1	2	3
Warren								1		1	3		2		1		6	2	8
Washington							1	1			1	2					2	3	5
ALBANY AREA TOTAL	2		2	11			73	188	141	159	94	61	119	51	48	17	478	489	967
Allegany								2		2			1				1	2	3
Cattaraugus							2	2		2							2	5	7
Chautauqua	1						4	15	7	12	2	6	6	4	3	1	22	39	61
Erie	3		2	33			150	348	227	240	115	109	123	96	94	30	713	859	1,572
Genesee								2	2	2		1	2	1	3		7	7	14
Niagara			1	10			22	41	29	29	20	22	30	9	20	4	122	115	237
Orleans							2	2	3	2		2	1	1	2		8	7	15
BUFFALO AREA TOTAL	4		3	43			180	410	268	289	137	140	163	111	122	36	875	1,034	1,909

TABLE IV (Continued)

Reported Cases of Gonorrhea
County, Area, Age, and Gender

2003

County	Age Gender	0 - 9		10 - 14		15-19		20-24		25-29		30-39		40+		TOTAL*		
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
Chemung					3	12	29	23	32	10	3	8	3	7	1	60	71	131
Livingston									2		1			2	1	2	4	6
Monroe	2			3	39	170	373	247	255	163	147	190	86	111	34	886	934	1,820
Ontario						1	4	4	8		1	2				7	13	20
Schuyler							2	1	1		1					1	4	5
Seneca								1		1		1				3		3
Steuben						2	3	1	5	3	1	2	2	1		9	11	20
Wayne						3	12	2	9	3	1	1		3	2	12	24	36
Yates								1						1		2		2
ROCHESTER AREA TOTAL		2		3	42	188	423	280	312	180	155	204	91	125	38	982	1,061	2,043
Broome					1	9	15	14	20	5	14	9	6	5	1	42	57	99
Cayuga					1	1	3	4	6	2	1	2	5		2	9	18	27
Chenango							2										2	2
Cortland						1	1	4	3	1						6	4	10
Herkimer						2	3	3	1		1	2				7	5	12
Jefferson							14	10	11	6	6	4	6	2		22	37	59
Lewis						1						1				2		2
Madison						1	3	4	3							5	6	11
Oneida					2	14	48	30	42	27	21	30	16	13	2	114	131	245
Onondaga				8	21	72	200	148	162	92	63	106	48	55	25	481	520	1,001
Oswego							2		3	1		1		1		3	5	8
St. Lawrence							3		4				2			2	9	11
Tioga								1	1			1	1			2	2	4
Tompkins						1	2	3	3	2		4				10	5	15
SYRACUSE AREA TOTAL				8	25	102	296	223	259	136	106	160	84	76	30	705	801	1,506

County	0 - 9		10 - 14		15 - 19		20 - 24		25 - 29		30 - 39		40 +		Total*		
Gender	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
Dutchess			1		18	31	31	40	20	17	22	17	7	1	99	108	207
Nassau				4	32	75	69	96	35	31	33	32	18	11	189	251	440
Orange	1		2		15	26	14	26	12	10	11	8	15	7	68	82	150
Putnam					1	1	2	2	1	1		3		1	2	8	10
Rockland					5	13	7	10	4	5	6	3	3	1	25	32	57
Suffolk			2		46	71	66	83	44	33	59	20	34	12	249	221	470
Sullivan			1		1	12	7	7		1	2	1	1	1	12	23	35
Ulster			3		6	24	15	15	6	5	10	7	4	4	41	58	99
Westchester	1		2	6	45	132	75	100	40	48	52	47	22	20	237	354	591
METRO NEW YORK AREA TOTAL	2	8	3	18	169	385	284	379	162	151	195	138	104	58	922	1,137	2,059
TOTAL	2	8	19	139	712	1,702	1,196	1,398	709	613	841	475	475	179	3,962	4,522	8,484

*Totals include individuals whose ages were unknown: 8 males and 8 females.

New York City

Age Group	Male	Female	Total §
0 - 9	1	4	5
10 - 14	25	119	144
15 - 19	842	2,032	2,884
20 - 24	1,825	2,059	3,903
25 - 29	1,324	1,054	2,392
30 - 34	992	587	1,582
35 - 39	764	386	1,153
40 +	868	388	1,261
Not Stated	79	62	144
TOTAL	6,720	6,691	13,468

§Totals include 57 individuals reported gender unknown.

**Reported Cases of Chlamydia Infection
County, Area, Age, and Gender**

2003

County Gender	0 - 9		10 - 14		15 - 19		20 - 24		25 - 29		30 - 39		40 +		Total*		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
Albany				14	58	287	89	252	49	86	33	32	12	7	241	679	920
Clinton				2	4	41	14	51	1	10	3	6	3		25	110	135
Columbia				1	7	24	6	22	1	10		3	3	2	17	62	79
Delaware					3	14	1	13	1	1		1			5	30	35
Essex						10	1	9		4		2		1	1	26	27
Franklin				1	1	29	3	9	1	3	1	2			6	45	51
Fulton				1	1	44	3	43	3	4	1	2	1		9	94	103
Greene						17	2	15	1	7	1		1	1	5	40	45
Hamilton						2											
Montgomery					2	17	1	18	1	6			1		5	2	2
Otsego					4	26	10	26	1	5					15	43	48
Rensselaer				4	18	103	25	73	14	22	8	9	2	1	67	212	279
Saratoga				2	5	78	22	59	9	21	3	7	4		43	167	210
Schenectady				7	22	147	35	122	24	37	14	35	6	13	101	361	462
Schoharie					3	9	3	10		2					6	22	28
Warren				1		21	3	29	4	5	1	4	1		9	60	69
Washington					3	19	2	20	2	5	1	1			8	45	53
ALBANY AREA TOTAL				33	131	888	220	771	112	228	66	108	34	26	563	2,057	2,620
Allegany					3	15	13	18	2	6	2	1			21	40	61
Cattaraugus					2	17	3	8		6			1		6	33	39
Chautauqua				2	11	79	33	95	3	28	8	11		3	58	219	277
Erie		1		1	175	1,016	279	788	139	238	84	122	27	40	707	2,278	2,985
Genesee	1				1	15	6	11	4	6	2				14	32	46
Niagara				1	29	177	55	128	23	65	14	16	6	2	129	399	528
Orleans					5	25	5	24		6	4	3		1	14	59	73
Wyoming					2	11	1	5	1	1	1				5	18	23
BUFFALO AREA TOTAL	1	1		85	228	1,355	395	1,077	172	356	115	155	34	46	954	3,078	4,032

TABLE V (Continued)
Reported Cases of Chlamydia Infection
County, Area, Age, and Gender

2003

County Gender	Age		0 - 9		10 - 14		15-19		20-24		25-29		30-39		40+		TOTAL*			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total	
Chemung Livingston Monroe Ontario Schuyler Seneca Steuben Wayne Yates ROCHESTER AREA TOTAL		1		5	19	71	30	55	3	10	6	5	3	2	61	149	210			
					8	37	8	22	1	6		1		1	18	68	86			
	3		4	97	306	1,229	395	844	173	286	131	167	57	22	1,066	2,649	3,715			
				2	3	52	11	37	3	12	1	5	1	2	19	111	130			
					1	4	1	7					1		3	11	14			
					1	12	6	9	1	3		3	1		9	27	36			
				1	5	35	10	33	7	5	1	7		1	23	83	106			
				1	6	50	13	41	11	8	2	3	3		35	103	138			
					1	9	1	4				1			2	14	16			
	4		4	106	350	1,499	475	1,052	199	330	141	192	67	29	1,236	3,215	4,451			
Broome Cayuga Chenango Cortland Herkimer Jefferson Lewis Madison Oneida Onondaga Oswego St. Lawrence Tioga Tompkins SYRACUSE AREA TOTAL	1	1		9	40	123	62	109	26	29	24	21	4	4	157	296	453			
					7	46	14	41	3	7	2	2	1		27	96	123			
				1	1	20	4	16	4	3	1	2	1		11	43	54			
				1	2	20	14	25	2	5		4			19	55	74			
	1			1		30	4	23	1	2	2	1			7	58	65			
				2	10	84	56	101	12	19	8	9	1	1	89	216	305			
						5	2	4		4	1		1	1	4	14	18			
				1	5	34	9	27	1	3	1	4			16	69	85			
				5	23	155	37	141	17	33	20	20	4	2	102	358	460			
	1	1	6	55	155	628	203	495	112	163	93	93	28	34	598	1,469	2,067			
					9	61	9	43	3	5	1	4	1	1	23	115	138			
					2	46	15	36	1	6	1	7		3	19	98	117			
					1	17	5	16	3	2		2	2		11	37	48			
				1	5	58	21	64	4	21	3	2	4		37	146	183			
		3	2	6	76	260	1,327	455	1,141	189	302	157	171	47	46	1,126	3,070	4,190		

**Reported Cases of Chlamydia Infection
County, Area, Age, and Gender**

2003

Age County Gender	0-9		10-14		15-19		20-24		25-29		30-39		40+		Total*		
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	Total
Dutchess					30	89	52	100	26	47	21	27	8	4	138	270	408
Nassau	1			1	99	411	185	452	87	171	82	115	26	27	482	1,196	1,678
Orange		1			26	142	36	158	18	43	12	41	7	9	100	396	496
Putnam					2	10	6	8	2	3	3	1		1	13	24	37
Rockland	1				14	91	27	104	16	45	16	29	5	4	79	281	360
Suffolk					56	476	121	457	74	185	47	103	26	14	324	1,248	1,572
Sullivan					7	59	5	39	5	5	1	1	2	3	20	110	130
Ulster					9	87	42	71	12	23	12	14	2	7	79	206	285
Westchester					65	457	119	454	77	163	43	126	22	37	328	1,267	1,595
METRO NEW YORK AREA TOTAL	2	1	2	77	308	1,822	593	1,843	317	685	237	457	98	106	1,563	4,998	6,561
TOTAL	6	8	16	377	1,277	6,891	2,138	5,884	989	1,901	716	1,08	280	253	5,436	16,418	21,854

*Totals include individuals whose ages were unknown: 8 males and 8 females.

New York City

Age Group	Male	Female	Total §
0-9	4	8	12
10-14	44	424	471
15-19	1,280	8,917	10,250
20-24	2,394	9,170	11,637
25-29	1,553	4,410	6,004
30-34	921	2,030	2,968
35-39	559	1,011	1,580
40+	563	988	1,558
Not Stated	79	215	299
TOTAL	7,397	27,173	34,779

§Totals include 299 individuals reported as gender unknown

TABLE VI

Reported Syphilis, by Stage, Gonorrhea, and Chlamydia Infection
Cases and Rates per 100,000 for Urban and Other Populations

2003

A R E A ***	A c q u i r e d S y p h i l i s *						G o n o r r h e a		C h l a m y d i a			
	Primary & Secondary		Early Latent **		Other		T O T A L		Cases	Rate		
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate				
Metropolitan	49	0.5	59	0.6	387	4.1	495	5.3	8,130	86.4	19,816	210.6
Central Cities	16	1.1	18	1.3	68	4.8	102	7.2	5,656	401.7	10,554	749.5
Other	33	0.4	41	0.5	319	4.0	393	4.9	2,474	30.9	9,262	115.8
Non-metropolitan	4	0.3	2	0.1	22	1.4	28	1.8	354	22.7	2,038	130.6
Upstate Total	53	0.5	61	0.6	409	3.7	523	4.8	8,484	77.4	21,854	199.2
New York City	531	6.6	951	11.9	2,301	28.7	3,783	47.2	13,468	168.2	34,779	434.3
TOTAL STATE	584	3.1	1,012	5.3	2,710	14.3	4,306	22.7	21,952	115.7	56,633	298.4

* Does not include congenital syphilis.

** Under one year's duration.

*** Metropolitan statistical areas include 31 counties and 21 central districts so designated by the Office of Management and Budget.

Central districts include Albany, Arlington, Binghamton, Buffalo, Cheektowaga, Elmira, Glens Falls, Ithaca, Kingston, Middletown, Newburgh, Niagara Falls, Poughkeepsie, Rochester, Rome, Schenectady, Syracuse, Tonawanda, Troy, Utica, and White Plains. Total population: 1,408,187

Metropolitan counties include Albany, Broome, Chemung, Dutchess, Erie, Herkimer, Livingston, Madison, Monroe, Montgomery, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Tioga, Ulster, Warren, Washington, Wayne, and Westchester. 2000 Census population: 9,407,239.

"Non-metropolitan" areas comprise 1,737,722 of the 10,968,179 residing outside New York City.

New York City's population in 2000 was 8,008,278 of the total State population of 18,976,457

Reported Cases of Early Syphilis, Gonorrhea and Chlamydia Infection - 2003

New York State exclusive of New York City

Age Group and Gender

A G E G R O U P																						
Disease Stage	Gender	Total Cases	<10	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+	Unknown							
Syphilis Primary	Male	22			1	3	1	4	4	3		3	1	2								
	Female																					
	Total	22			1	3	1	4	4	3		3	1	2								
Secondary	Male	27				5	1	4	6	7	2		2									
	Female	4					2	1			1											
	Total	31				5	3	5	6	7	3		2									
Early Latent	Male	42			1	7	4	9	8	7	4	2										
	Female	19			3	3	8	3	2													
	Total	61			4	10	12	12	10	7	4	2										
Total Early	Male	91			2	15	6	17	18	17	6	5	3	2								
	Female	23			3	3	10	4	2		1											
	Total	114			5	18	16	21	20	17	7	5	3	2								
Late & Latent	Male	225			2	7	21	24	35	46	24	21	13	32								
	Female	183			2	14	17	23	29	30	14	18	6	30								
	Total	408			4	21	38	47	64	76	38	39	19	62								
All Stages	Male	316			4	22	27	41	53	63	30	26	16	34								
	Female	206			5	17	27	27	31	30	15	18	6	30								
	Total	522			9	39	54	68	84	93	45	44	22	64								
Gonorrhea	Male	3,962	2	19	712	1,196	709	484	357	232	115	76	23	29	8							
	Female	4,522	8	139	1,702	1,398	613	304	171	116	41	13	5	4								
	Total	8,484	10	158	2,414	2,594	1,322	788	528	348	156	89	28	33	16							
Chlamydia Infection	Male	5,436	6	16	1,277	2,138	989	464	252	160	64	35	10	11	14							
	Female	16,418	8	377	6,893	5,885	1,901	757	326	144	61	20	13	12	21							
	Total	21,854	14	393	8,170	8,023	2,890	1,221	578	304	125	55	23	23	35							

TABLE VII B

Case Rates for Reported Early Syphilis, Gonorrhea, and Chlamydia Infection - 2003

New York State exclusive of New York City

Age Group and Gender

Disease Stage	Gender	Total Cases	A G E G R O U P																		
			<10	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60+							
Syphilis Primary	Male	0.4			0.3	0.9	0.3	1.1	0.9	0.7									0.8	0.4	0.2
	Female																				
	Total	0.2		0.1	0.5	0.2	0.5	0.5	0.4	0.3									0.4	0.2	0.1
Secondary	Male	0.5				1.5	0.3	1.1	1.3	1.5							0.5	0.5		0.7	
	Female	0.1					0.6	0.3	0.6								0.2	0.2			
	Total	0.3			0.8	0.5	0.7	0.7	0.7	0.8							0.4	0.4		0.4	0.1
Early Latent	Male	0.8		0.3	2.1	1.3	2.4	1.8	1.5	1.0									0.6		
	Female	0.3		0.8	0.9	2.6	0.8	0.4													
	Total	0.6		0.5	1.5	1.9	1.6	1.1	0.8	0.5									0.3		
Total Early	Male	1.7		0.5	4.4	1.9	4.5	4.0	3.7	1.5									1.4	1.1	0.2
	Female	0.4		0.8	0.9	3.2	1.0	0.4		0.2											
	Total	1.0		0.7	2.7	2.6	2.8	2.2	1.9	0.9									0.7	0.5	0.1
Late & Latent	Male	4.2		0.5	2.1	6.8	6.4	7.8	10.1	6.0									5.9	4.8	3.9
	Female	3.3		0.5	4.4	5.5	6.0	6.2	6.5	3.4									4.8	2.1	2.7
	Total	3.7		1.0	3.2	6.2	6.2	7.0	8.3	4.7									5.4	3.4	3.2
All Stages	Male	5.9		0.5	6.5	8.8	10.8	11.8	13.8	7.5									7.3	5.9	4.1
	Female	3.7		0.5	5.3	8.7	7.0	6.7	6.5	3.6									4.8	2.1	2.7
	Total	4.8		0.5	5.9	8.7	8.9	9.2	10.1	5.5									6.1	3.9	3.3
Gonorrhea	Male	74.1	0.3	4.6	182.5	351.9	230.3	128.1	79.2	28.8									21.5	8.5	3.5
	Female	80.5	1.1	35.8	465.5	439.9	198.1	79.1	36.8	9.9									3.5	1.7	0.4
	Total	77.4	0.7	19.7	319.4	394.5	214.2	103.4	57.7	19.2									12.3	5.0	1.7
Chlamydia Infection	Male	101.6	0.8	3.9	327.3	629.1	321.3	122.8	55.9	16.0									9.9	3.7	1.3
	Female	292.2	1.1	97.1	1885.1	1851.9	614.3	197.0	70.1	14.8									5.4	4.5	1.1
	Total	199.2	0.9	49.1	1080.9	1226	468.2	160.2	63.1	15.4									7	4.1	1.2

Reported Cases of Early Syphilis, Gonorrhea, and Chlamydia Infection - 2003

New York City
Age Group and Sex

Disease	Stage	Sex	Total Cases	A G E G R O U P																	60+	Unknown				
				<10	10-	14	15-	19	20-	24	25-	30-	34	35-	40-	44	45-	49	50-	54			55-			
Syphilis	Primary	Male	141																							
		Female	9																							
		Total	150																							
	Secondary	Male	368																							
		Female	13																							
		Total	381																							
	Early Latent	Male	774																							
		Female	177																							
		Total	951																							
	Total Early	Male	1,283																							
		Female	199																							
		Total	1,482																							
	Late & Late Latent	Male	1,341																							
		Female	929																							
		Total*	2,301																							
	All Stages	Male	2,624																							
		Female	1,128																							
		Total*	3,783																							
	Gonorrhea	Male	6,720																							
		Female	6,691																							
		Total*	13,468																							
	Chlamydia Infection	Male	7,397																							
		Female	27,173																							
		Total*	34,779																							

* Includes 31 cases of late or late latent syphilis, 57 cases of gonorrhea, and 209 cases of Chlamydia infection whose gender was not stated.

TABLE VIII B

Case Rates for Reported Cases of Early Syphilis, Gonorrhea, and Chlamydia Infection - 2003

New York City

Age Group and Sex

Disease Stage	Sex	Total Cases	A G E G R O U P																			
			<10	10-	14	15-	19	20-	24	25-	30-	34	35-	40-	44	45-	49	50-	54	55-	59	60+
Syphilis Primary	Male	3.7				1.9		6.3		7.8		7.0		8.5		8.1		2.0		1.8		5.5
	Female	0.2				0.8		0.3		0.3		0.6		0.3		0.6						
	Total	1.9				1.4		3.2		3.9		3.7		4.3		4.2		0.9		0.8		2.5
Secondary	Male	9.7		0.4		3.8		7.8		15.9		20.6		27.5		23.6		13.0		8.2		3.1
	Female	0.3				0.8		0.7		0.3		0.9		0.3						0.8		1.0
	Total	4.8		0.2		2.3		4.1		7.8		10.5		13.5		11.3		6.1		4.2		1.9
Early Latent	Male	20.5		0.4		6.5		22.9		26.9		52.7		52.8		43.8		27.2		12.8		12.3
	Female	4.2		0.4		7.2		9.8		6.6		6.6		7.5		8.9		2.8		3.9		3.5
	Total	11.9		0.4		6.8		16.1		16.3		29.1		29.6		25.6		14.3		8.0		7.4
Total Early	Male	33.9		0.7		12.3		37.0		50.6		80.3		88.8		75.5		42.1		22.9		20.8
	Female	4.7		0.4		8.8		10.8		7.1		8.0		8.1		9.5		2.8		4.6		4.4
	Total	18.5		0.6		10.6		23.5		27.9		43.2		47.4		41.0		21.3		13.0		11.7
Late & Latent	Male	35.4				4.2		14.8		29.0		45.8		77.5		106.5		69.3		40.3		44.1
	Female	22.0				4.0		13.1		18.3		38.2		58.6		54.1		29.1		22.3		19.7
	Total	28.7				4.1		13.9		23.6		42.5		68.4		81.0		48.6		31.2		30.9
All Stages	Male	69.3				16.5		51.8		79.6		126.1		166.3		182.0		111.4		63.2		65.0
	Female	26.7				12.8		24.0		25.4		46.2		66.7		63.6		31.9		27.0		24.2
	Total	47.2				14.7		37.4		51.5		85.7		115.8		122.0		69.9		44.2		42.6
Gonorrhea	Male	177.6	0.2	9.1		322.6		643.4		413.5		300.6		233.1		159.1		83.5		46.7		30.0
	Female	158.4	0.7	45.7		811.1		675.7		301.3		168.6		112.0		66.4		33.6		18.1		7.9
	Total	168.2	0.5	26.9		563.8		663.3		357.0		233.3		171.5		111.0		57.7		31.2		17.8
Chlamydia Infection	Male	195.5	0.7	16.0		490.4		843.9		485.1		279.1		170.5		110.2		47.6		25.2		20.2
	Female	643.3	1.5	162.8		3,559.5		3,009.4		1,260.8		583.1		293.3		156.2		86.9		47.0		26.1
	Total	434.3	1.1	87.9		2,003.8		1,977.8		896.2		437.7		234.9		135.2		68.6		37.0		23.5

Figure V

AGE, GENDER-SPECIFIC INCIDENCE RATES EARLY SYPHILIS

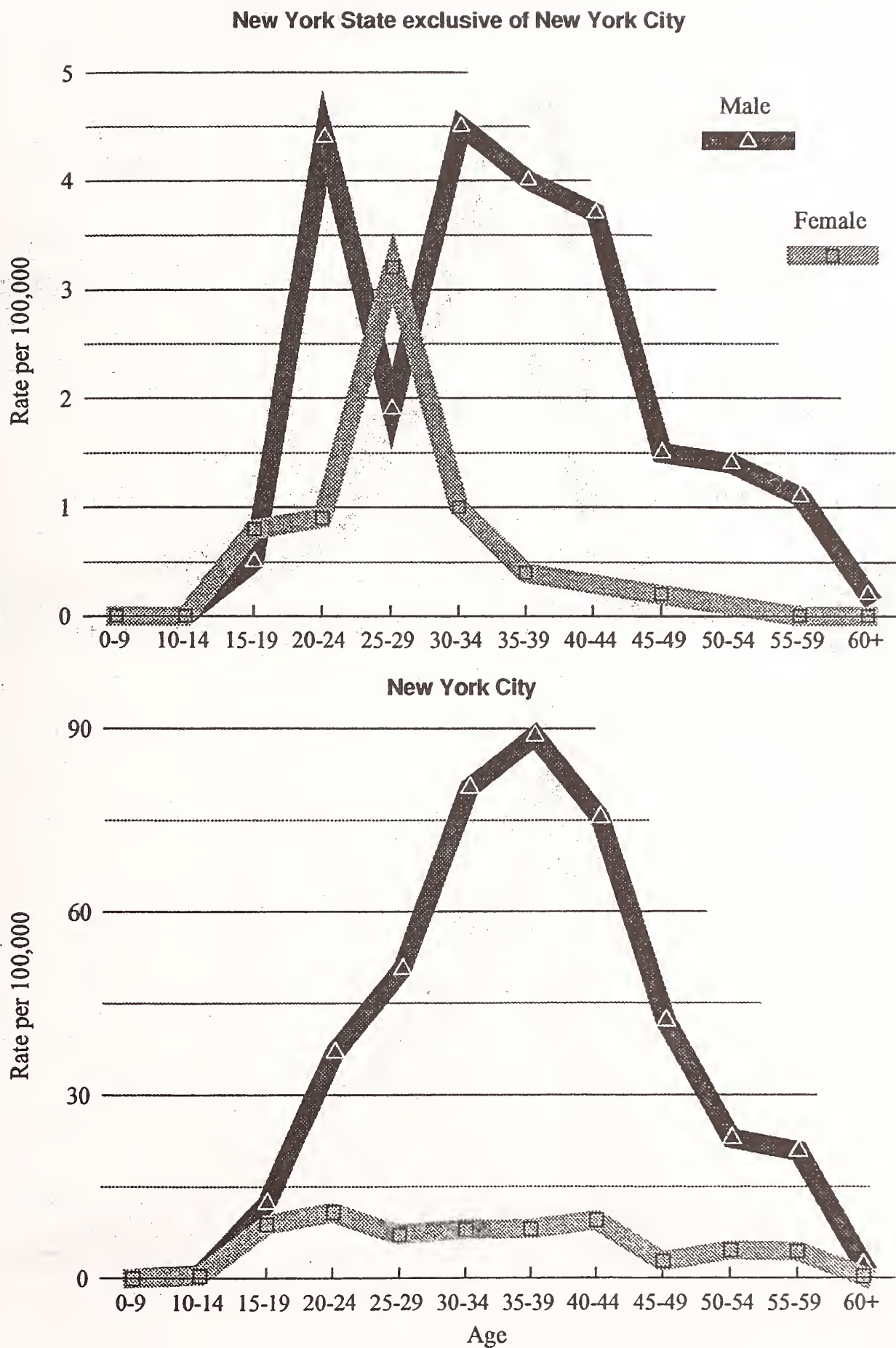


Figure VI
AGE, GENDER-SPECIFIC INCIDENCE RATES
GONORRHEA

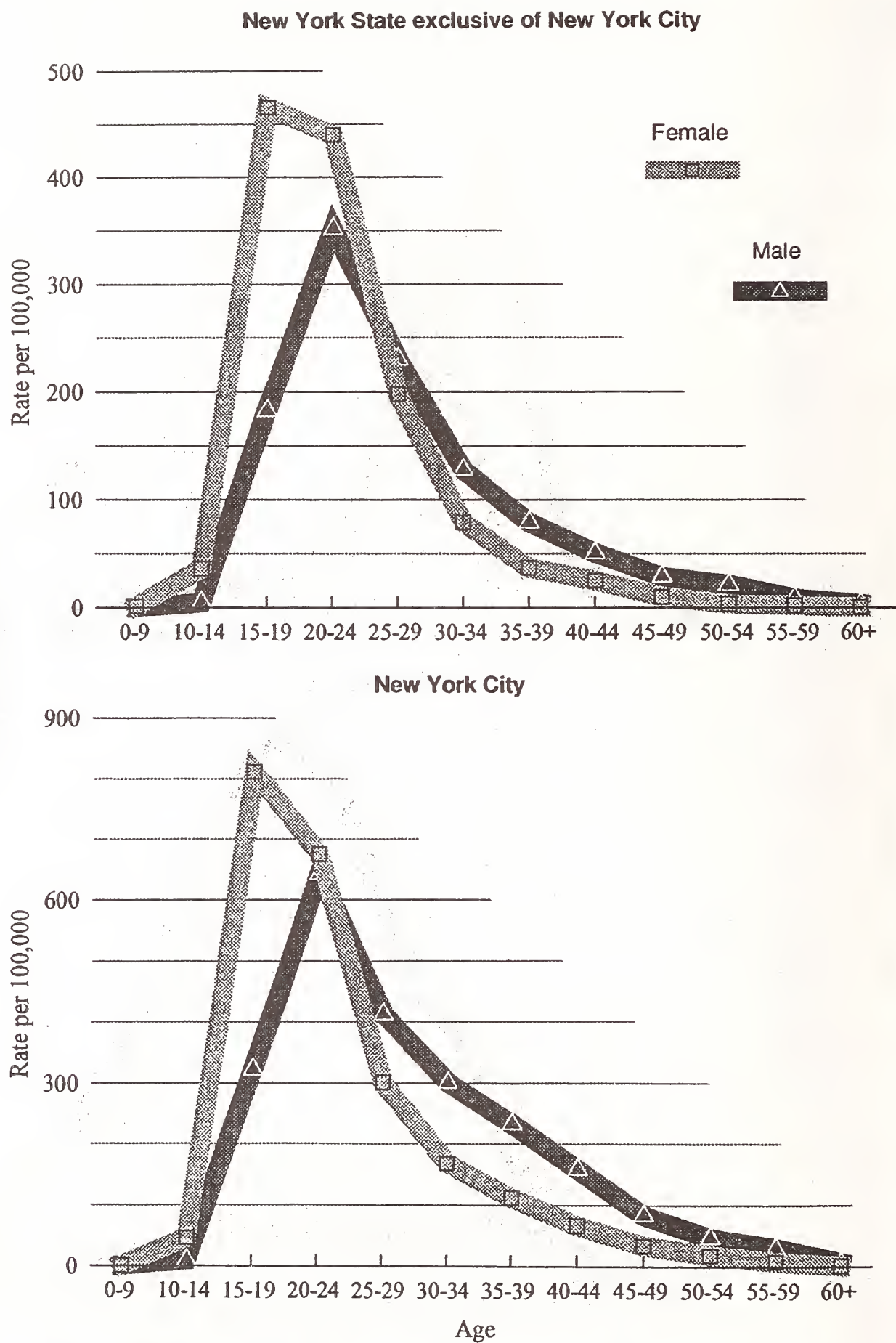


Figure VII

AGE, GENDER-SPECIFIC INCIDENCE RATES CHLAMYDIA INFECTION

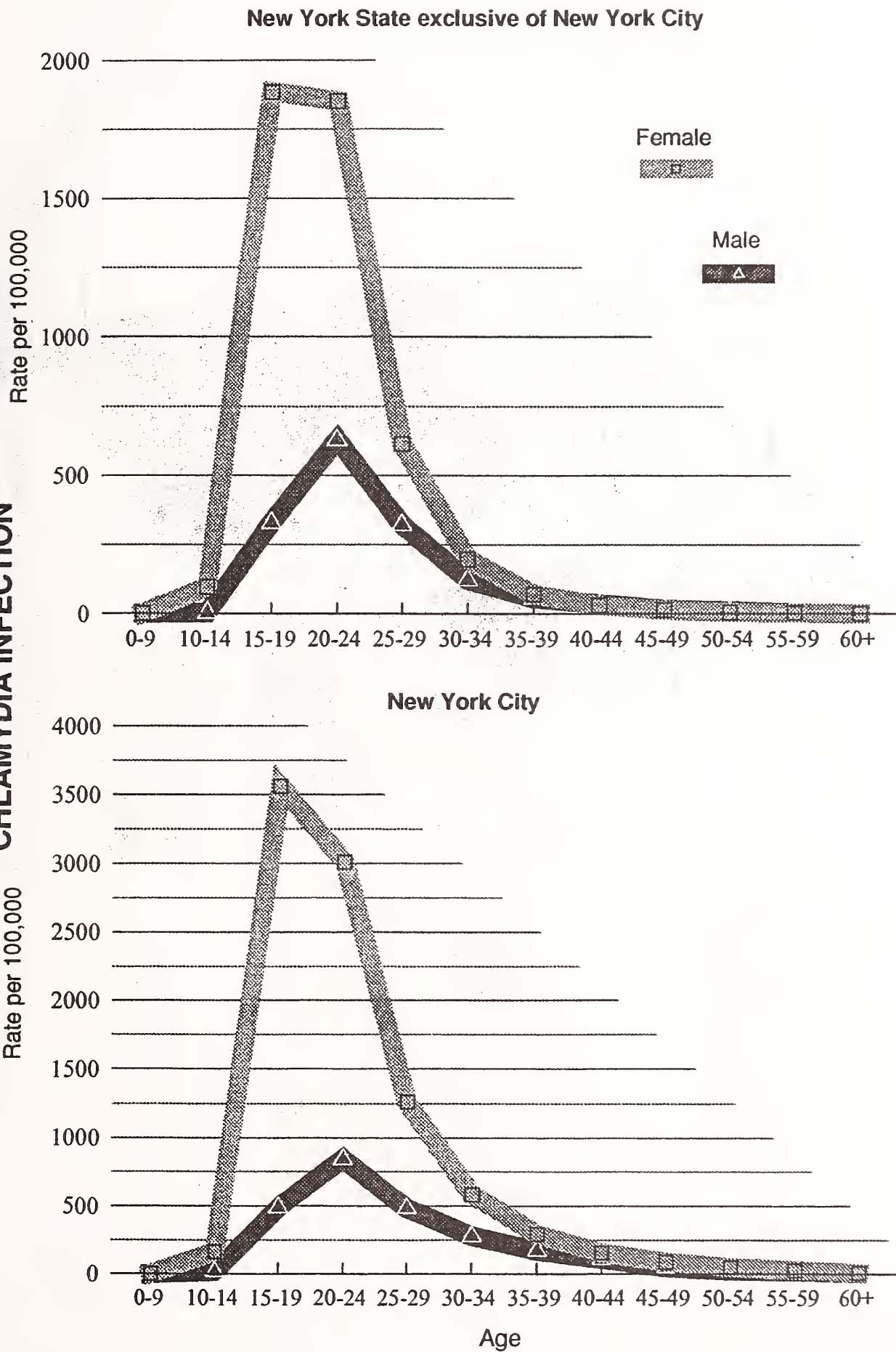


Figure XI

CONGENITAL SYPHILIS AMONG INFANTS

2003

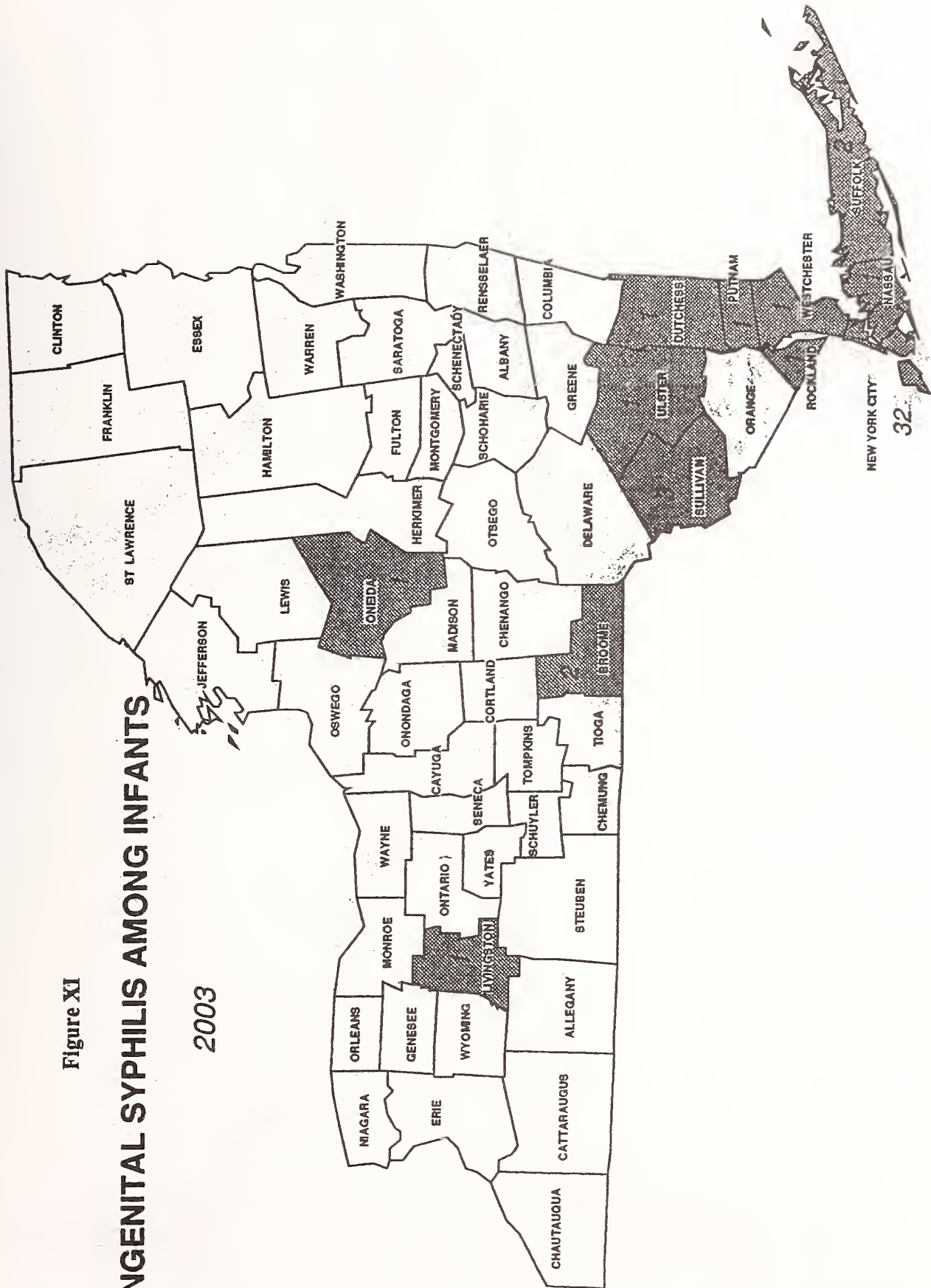


Figure XII

REPORTED CASES OF CONGENITAL SYPHILIS AMONG INFANTS



TABLE IX

Demographic Characteristics of Females Screened for Chlamydial Infection in Sentinel Sites - 2003

	STD Clinics (4)				Correction Facilities (3)				Mobile Van & Needle Exchange Program			
	Total*	Negative	Positive	Percent Positive	Total*	Negative	Positive	Percent Positive	Total*	Negative	Positive	Percent Positive
Age Group												
<10	18	15	1	6.3	2	2		0.0				
10-14	117	89	22	19.8	38	34	3	8.1				
15-19	1,758	1,390	256	15.6	460	399	38	8.7	6	6		0.0
20-24	2,305	1,981	184	8.5	216	189	12	6.0	8	7		0.0
25-29	1,149	1,033	57	5.2	10	9		0.0	3	3		0.0
30+	2,572	2,388	41	1.7	1	1		0.0	26	26		0.0
Missing	28	24	2	7.7	3	3		0.0				
Race												
Black	4,177	3,605	332	8.4	228	194	18	8.5	17	17		0.0
White	2,662	2,345	158	6.3	236	211	8	3.7	22	21		0.0
Other	440	383	37	8.8	77	71	3	4.1	3	3		0.0
Missing	668	587	36	5.8	189	161	24	13.0	1	1		0.0
Ethnicity												
Hispanic	671	582	48	7.6	55	48	4	7.7	10	9		0.0
Non-Hispanic	6,349	5,516	465	7.8	250	218	12	5.2	16	16		0.0
Missing	927	822	50	5.7	425	371	37	9.1	17	17		0.0
TOTAL	7,947	6,920	563	7.5	730	637	53	7.7	43	42		0.0

Due to the inclusion of *suspicious* and *unsatisfactory* test results, the total is not always the sum of positive plus negative tests. Percentages positive, however, are calculated with use of only their sum as denominator.

TABLE X

Screening for Chlamydial Infection in Prevalence Monitoring Sites - 2003

	Females				Males			
	Total*	Negative	Positive	Percent Positive	Total*	Negative	Positive	Percent Positive
Clinic Type								
FP (212 sites)	56,111	53,733	2,371	4.2	3,430	3,119	311	9.1
STD (10)	2,236	2,041	195	8.7	3,513	3,060	453	12.9
Adolescent HC (2)	660	585	75	11.4	71	59	12	16.9
College HC (5)	2,053	1,985	68	3.3	272	245	27	9.9
Community HC (4)	1,216	1,176	40	3.3	64	58	6	9.4
Age Group								
<10	107	105	2	1.9	17	17		0.0
10-14	302	270	31	10.3	27	25	2	7.4
15-19	12,354	11,304	1,048	8.5	1,271	1,059	212	16.7
20-24	14,949	14,204	744	5.0	2,376	2,032	344	14.5
25-29	7,645	7,457	187	2.4	1,098	987	111	10.1
30+	12,429	12,273	154	1.2	1,829	1,727	102	5.6
NS	14,490	13,907	583	4.0	732	694	38	5.2
Race								
Black	8,930	8,324	605	6.8	1,825	1,510	315	17.3
White	5,767	5,536	225	3.9	2,015	1,847	168	8.3
Other	7,200	6,920	280	3.9	861	767	94	10.9
Missing	40,379	38,740	1,639	4.1	2,649	2,417	232	8.8
Ethnicity								
Hispanic	12,069	11,639	430	3.6	1,311	1,184	127	9.7
Non-Hispanic	14,430	13,634	789	5.5	2,929	2,540	389	13.3
Missing	35,777	34,247	1,530	4.3	3,110	2,817	293	9.4
Total	62,276	59,520	2,749	4.4	7,350	6,541	809	11.0

Due to the inclusion of *suspicious* and *unsatisfactory* test results, the total is not the sum of positive plus negative tests. Percentages positive, however, are calculated with use of only their sum as denominator.



Eliminating Syphilis -- New York

Key features of syphilis in the U.S. in 2003

Syphilis is a preventable and curable sexually transmitted disease (STD). Syphilis disproportionately affects a small percentage of the population and research shows that these are often isolated groups involved in high-risk activities such as illicit drug use, exchanging sex for money or drugs, unprotected sexual intercourse and having multiple sex partners.

- U.S. primary and secondary (P&S) syphilis rate in 2003 was 2.5 cases/100,000 population (7,177 cases).
- U.S. congenital syphilis rate was 10.3 cases/100,000 live births (413 cases).
- Half of U.S. P&S cases in 2003 were in 19 counties, less than 1% of 3,140 counties.

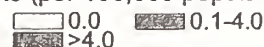


Key features of syphilis in New York in 2003

Primary and secondary syphilis cases, rates and rank

- New York's 584 cases ranked 5 among 50 states, District of Columbia and 3 territories.
- New York's rate of 3 cases/100,000 population ranked 12 among 50 states, District of Columbia and 3 territories.
- New York's rate was 1.2 times the U.S. rate of 2.5 cases/100,000 population.

Rate (per 100,000 population)



New York Rates

Male-female ratios (primary and secondary syphilis)

- In New York, 558 (96%) cases in 2003 were among males, compared to 83% nationally. The rate among males (6/100,000) was 1.4 times that of the U.S. male rate (4.2/100,000).
- In New York, 26 (4%) cases were among females, compared to 17% nationally. The rate among females (0.3/100,000) was 0.3 times that of the U.S. female rate (0.8/100,000).
- The ratio of male to female rates in New York was 23.2:1.0, higher than the U.S. ratio of 4.9:1.0.

Racial disparities (primary and secondary syphilis)

- In New York in 2003, the racial distribution of the 584 cases was: White = 175; Black = 121; Hispanics = 130; Asian = 9; American Indian = 1. The race adjusted rates (per 100,000 population) were: White = 2; Black = 5.4; Hispanics = 5.6; Asian = 0.9; American Indian = 1.4.
- 40.1% of cases were among Whites, compared to 42% nationally.
- 27.7% of cases were among Blacks, compared to 39% nationally. The rate among Blacks (5.4) was 2.7 times that of Whites (2).
- 29.8% of cases were among Hispanics, compared to 16% nationally. The rate among Hispanics (5.6) was 2.8 times that of Whites (2).
- 2.1% of cases were among Asians, compared to 2% nationally. The rate among Asians (0.9) was 0.5 times that of Whites (2).
- 0.2% of cases were among American Indians, compared to 1% nationally. The rate among American Indians (1.4) was 0.7 times that of Whites (2).

Congenital Syphilis

Syphilis can be transmitted from mother to fetus during pregnancy causing stillbirths or congenital syphilis that may result in lifelong health problems.

- New York had 42 congenital syphilis cases born in 2003.
- The congenital syphilis rate in the state was 16.7 cases/100,000 live births.
- The congenital syphilis rate in New York was 1.6 times the U.S. rate of 10.3/100,000 live births.

What's in this report?

HIV and AIDS in New York City: An Overview	1
Age-Adjusted Death Rates Among Persons with AIDS, 1988 – 2004	1
Reported HIV/AIDS Diagnoses and Deaths, January – March 2005, and PLWHA as of March 31, 2005	2
Which HIV-Related Events are Reportable?	2
Foreign-Born Persons Newly Diagnosed with HIV, New York City 2004	3
HIV/AIDS in UHF Neighborhoods in 2004	4

Publication schedule: This report reflects events occurring through March 31, 2005, and reported by December 31, 2005, unless otherwise stated. It represents diagnoses made through nine months prior to the publication date because case reporting is 85% complete by that time. Because cases continue to be reported for many months, the final numbers can be expected to be higher.

To receive this report via e-mail, send an e-mail request to:
hivreport@health.nyc.gov

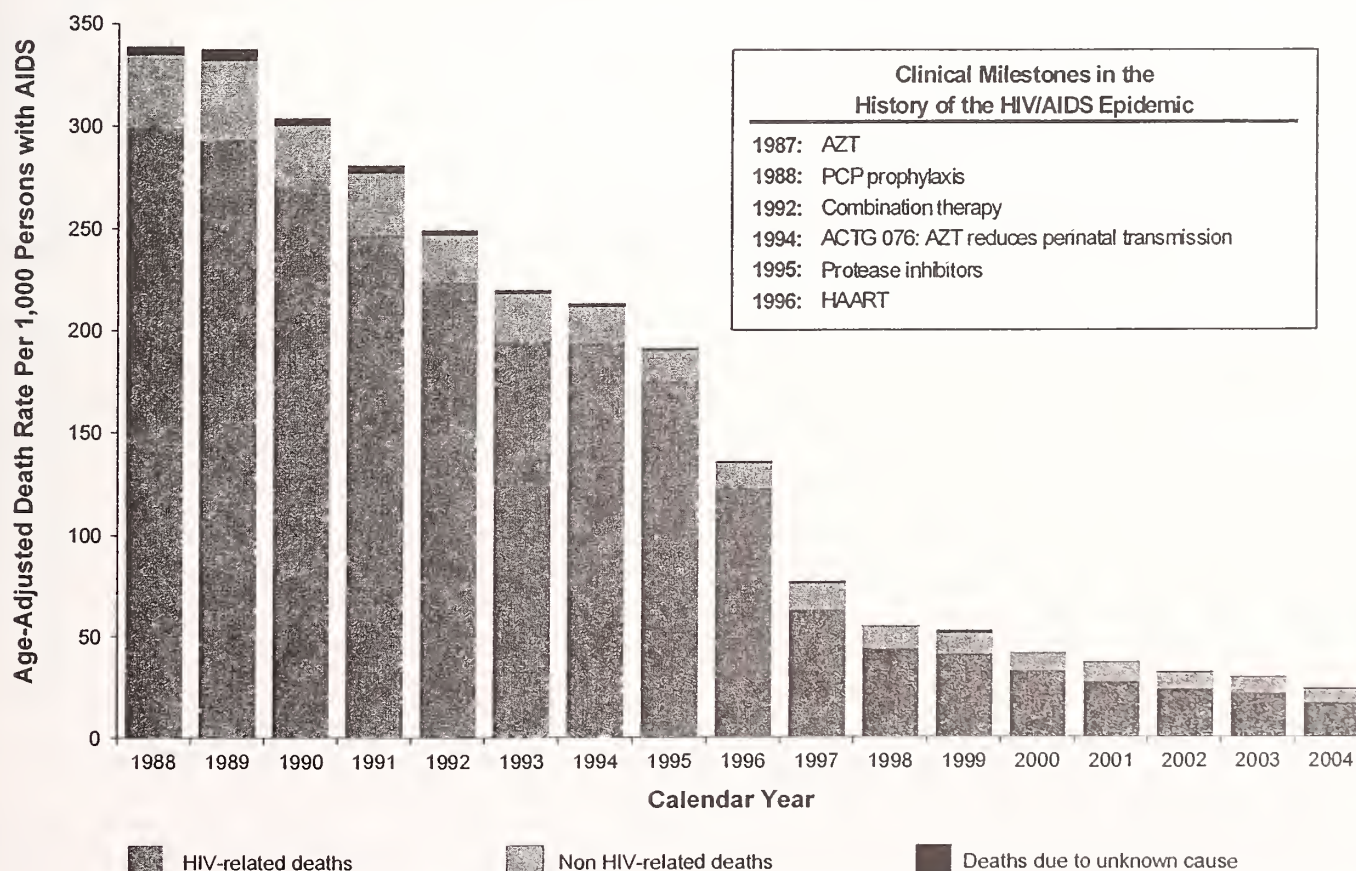
For electronic versions of this and other HIV-related reports, visit:
<http://www.nyc.gov/html/doh/html/dires/hivepi.shtml>

HIV Epidemiology Program
346 Broadway, Room 706, CN44, New York, NY 10013
Tel: (212) 442-3388 Fax: (212) 788-2520

HIV AND AIDS IN NEW YORK CITY: AN OVERVIEW

- As of March 31, 2005, 95,707 New Yorkers had been diagnosed and were known to be living with HIV/AIDS, including 34,246 living with HIV (non-AIDS) and 61,461 living with AIDS.
 - The true number of persons living with HIV/AIDS (PLWHA) in NYC is higher. It is estimated that 25% of persons living with HIV have never been tested and thus do not know they are infected.
- Compared to the first quarter of 2004, during the first quarter of 2005:
 - The number of new HIV diagnoses was relatively unchanged, 908 versus 912.
 - The number of new AIDS diagnoses decreased from 1,096 to 986.
 - The proportion of new HIV diagnoses accounted for by men increased from 66.6% to 73.4%.
 - The proportion of new HIV diagnoses accounted for by men who have sex with men (MSM) increased from 30.5% to 37.6%.
- Between 2003 and 2004, the age-adjusted death rate per 1,000 PWA declined 21.8% for HIV-related causes and 16.3% for non-HIV-related causes.

Age-Adjusted Death Rate Per 1,000 Persons with AIDS, New York City 1988 - 2004



Reported HIV/AIDS diagnoses and deaths occurring January 1, 2005 through March 31, 2005, and reported persons living with HIV/AIDS as of March 31, 2005¹, in New York City

	HIV diagnoses 1/1/2005–3/31/2005 ¹						AIDS diagnoses 1/1/2005–3/31/2005 ³		PLWHA as of 3/31/2005		Deaths 1/1/2005–3/31/2005	
	Total		Without AIDS		Concurrent with AIDS diagnosis ²		N	%	N	%	N	%
	N	%	N	%	N	%						
Total	912	100.0	677	74.2	235	25.8	986	100.0	95,707	100.0	588	100.0
Sex												
Male	669	73.4	494	73.0	175	74.5	680	69.0	66,511	69.5	393	66.8
Female	243	26.6	183	27.0	60	25.5	306	31.0	29,010	30.3	195	33.2
Unknown	0	0.0	0	0.0	0	0.0	0	0.0	186	0.2	0	0.0
Race/Ethnicity												
Black	473	51.9	347	51.3	126	53.6	535	54.3	42,516	44.4	310	52.7
Hispanic	277	30.4	195	28.8	82	34.9	304	30.8	30,432	31.8	185	31.5
White	131	14.4	110	16.2	21	8.9	130	13.2	20,424	21.3	88	15.0
Asian/Pacific Islander	26	2.9	20	3.0	6	2.6	11	1.1	1,096	1.1	*	*
Native American	*	*	*	*	0	0.0	*	*	77	0.1	0	0.0
Other/unknown	*	*	*	*	0	0.0	*	*	1,162	1.2	*	*
Age group (years)⁴												
0-12	*	*	*	*	0	0.0	0	0.0	1,078	1.1	*	*
13-19	34	3.7	30	4.4	*	*	10	1.0	1,440	1.5	*	*
20-29	201	22.0	166	24.5	35	14.9	121	12.3	5,545	5.8	11	1.9
30-39	290	31.8	218	32.2	72	30.6	284	28.8	21,337	22.3	84	14.3
40-49	234	25.7	162	23.9	72	30.6	348	35.3	37,874	39.6	217	36.9
50-59	110	12.1	74	10.9	36	15.3	171	17.3	21,538	22.5	206	35.0
60+	40	4.4	24	3.5	16	6.8	52	5.3	6,895	7.2	68	11.6
Borough of residence												
Manhattan	258	28.3	195	28.8	63	26.8	279	28.3	29,783	31.1	159	27.0
Brooklyn	261	28.6	186	27.5	75	31.9	284	28.8	23,656	24.7	173	29.4
Bronx	203	22.3	142	21.0	61	26.0	236	23.9	20,864	21.8	140	23.8
Queens	134	14.7	105	15.5	29	12.3	128	13.0	12,942	13.5	78	13.3
Staten Island	17	1.9	16	2.4	*	*	15	1.5	1,716	1.8	13	2.2
Unknown/outside NYC	39	4.3	33	4.9	6	2.6	44	4.5	6,746	7.0	25	4.3
Transmission risk												
Men who have sex with men	343	37.6	263	38.8	80	34.0	276	28.0	26,958	28.2	64	10.9
Injection drug use history	69	7.6	49	7.2	20	8.5	162	16.4	22,231	23.2	249	42.3
Heterosexual ⁵	137	15.0	97	14.3	40	17.0	174	17.6	17,695	18.5	101	17.2
Perinatal	*	*	*	*	0	0.0	*	*	2,451	2.6	*	*
Other	*	*	*	*	0	0.0	*	*	534	0.6	*	*
Unknown/under investigation ⁶	359	39.4	264	39.0	95	40.4	369	37.4	25,838	27.0	165	28.1
Clinical status as of 3/31/2005												
HIV (non-AIDS)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	34,246	35.8	59	10.0
AIDS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	61,461	64.2	529	90.0

PLWHA=Persons living with HIV/AIDS. Cells representing 1-5 person(s) are marked with an asterisk (*).

¹ For events reported by December 31, 2005.

² HIV diagnosed concurrently with AIDS (within 31 days of HIV diagnosis).

³ AIDS was diagnosed in 2005 and includes concurrent HIV/AIDS diagnosis.

⁴ For HIV and AIDS diagnoses, age at diagnosis; for PLWHA, age as of March 31, 2005; and for deaths, age at death.

⁵ Includes persons with CDC-defined heterosexual risk and persons with probable heterosexual transmission. CDC heterosexual risk is defined as sex with an HIV-infected person of the opposite sex, an injection drug user, a bisexual male or a person with hemophilia/coagulation disorder. Probable heterosexual transmission is defined as a history of a) heterosexual prostitution, b) sex with a prostitute of the opposite sex, c) multiple sex partners of the opposite sex, d) sexually transmitted disease, e) crack/cocaine use or f) immigration from a country where heterosexual transmission of HIV predominates.

⁶ Includes individuals with no risk information reported by the provider and for whom an expanded investigation has not been completed.

Which HIV-related events are reportable in New York State, and who is required to report?

In 1998, New York State expanded AIDS case reporting to include HIV (Chapter 163 of the Laws of 1998, PHL Article 21). The law took effect on June 1, 2000 and was amended on June 1, 2005. All diagnostic and clinical providers (doctors, nurses, physician assistants, and all others diagnosing HIV or providing care to HIV-infected persons) and laboratories are required by law to report the following events:

Events reportable by providers on the required New York State Provider Report Form (PRF)

- Diagnoses of HIV infection
- Diagnoses of HIV illness in a previously unreported individual (i.e., HIV illness not meeting the AIDS case definition)
- Diagnoses of AIDS-defining conditions

Events reportable by laboratories

- All positive Western blot test results
- All viral load test results (detectable and undetectable)
- All CD4 test results
- All viral nucleotide sequence results

For assistance in reporting a case of HIV/AIDS, to receive Provider Report Forms, or to obtain more information, please call
(212) 442-3388



TALK TO US
CNAP
(212) 693-1419

New York State law also requires that PRFs contain names of sexual or needle-sharing partners of the infected person known to medical providers or those whom the infected person wishes to have notified of their possible exposures. Providers can utilize and/or refer HIV-infected persons to the NYC DOHMH Contact Notification Assistance Program (CNAP) at (212) 693-1419 for assistance in carrying out partner notification.

For more information about the New York State HIV reporting and partner notification law and CNAP, visit:

www.health.state.ny.us/nysdoh/hiv/aids/hivpartner/intro.htm

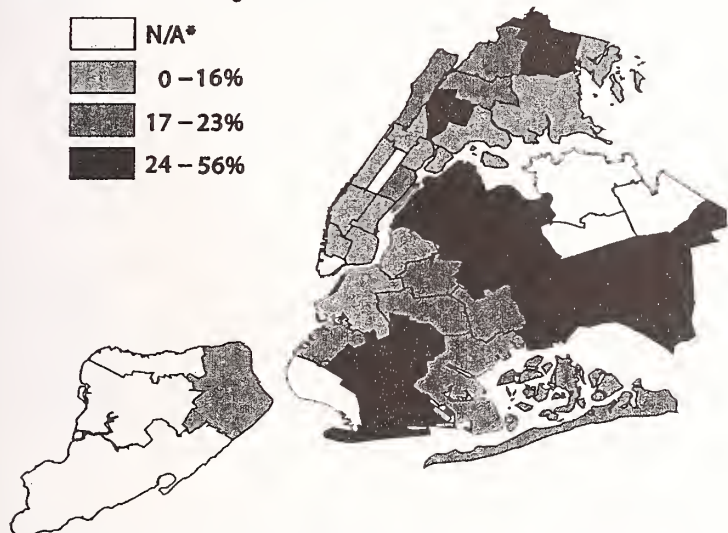
Foreign-Born Persons Newly Diagnosed with HIV, New York City 2004

Over the past two decades, New York City has experienced rapid growth in the foreign-born population; that growth is expected to continue.¹ Currently, an estimated 35.9% percent of New York City's population is foreign-born.² Of all the boroughs, the highest percentage of foreign-born persons resides in Queens (46.1%, n=1,028,339), followed by Brooklyn (37.8%, n=931,769), Manhattan (29.4%, n=452,440), the Bronx (29.0%, n=385,827) and Staten Island (16.4%, n=72,657).²

Available data indicate that foreign-born New Yorkers are less likely to have insurance and a primary care provider than those born in the United States, and therefore may face barriers to accessing health care, including HIV testing and treatment.¹ In 2004, HIV was newly diagnosed in 845 persons born in a foreign country (23.1% of all HIV diagnoses), 121 persons born in a U.S. dependency, primarily Puerto Rico (3.3%) and 1,459 persons born in the U.S. (39.9%). Area of birth was unknown for 1,228 persons (33.6%).³

New HIV diagnoses in the boroughs and United Hospital Fund (UHF) neighborhoods of New York City, 2004³

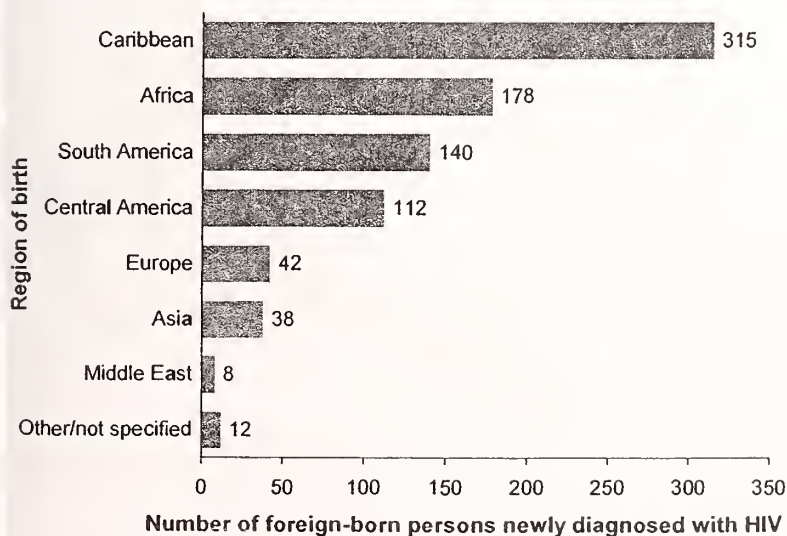
Percentage of persons newly diagnosed with HIV who are foreign-born



* Data not shown for UHF neighborhoods with fewer than 20 persons newly diagnosed with HIV in 2004

- Neighborhoods in the Bronx, Brooklyn and Queens have the highest percentage of persons newly diagnosed with HIV who are foreign-born. West Queens is the UHF neighborhood with the highest percentage (55.3%, n=84).
- Of all the boroughs, Queens has the highest percentage of persons with new HIV diagnoses who are foreign-born (42.6%, n=233), followed by Brooklyn (24.3%, n=241), the Bronx (20.5%, n=184), Staten Island (20.5%, n=15) and Manhattan (14.2%, n=136).⁴
- The top country of birth among foreign-born persons newly diagnosed with HIV is the Dominican Republic in Manhattan (12.5%, n=17) and the Bronx (14.7%, n=27), Haiti (15.4%, n=37) in Brooklyn, and Mexico (12.0%, n=28) in Queens.

Region of birth among foreign-born persons newly diagnosed with HIV, New York City 2004³



- Persons born in the Caribbean comprise the largest percentage of new HIV diagnoses among the foreign-born (37.3%, n=315), followed by Africa (21.1%, n=178), South America (16.6%, n=140) and Central America (13.3%, n=112).
- Persons newly diagnosed with HIV born in Africa are primarily from sub-Saharan countries, including Ghana (12.9%, n=23), Cote d'Ivoire (10.7%, n=19), Nigeria (10.7%, n=19) and Zambia (9.0%, n=16). More than half reside in neighborhoods in the Bronx, Central Brooklyn and Harlem.
- Almost one-half of persons newly diagnosed with HIV born in South and Central America live in Queens (45.2%, n=114).

¹ Van Wye G, Kim M, Kerker B, Thorpe L, Frieden TR. *The Health of Immigrants in New York City*. New York: New York City Department of Health and Mental Hygiene, 2006.

² U.S. Census Bureau. *Census 2000*. Washington DC 2002.

³ Based on data reported through September 30, 2005.

⁴ Borough information is unknown for 36 foreign-born persons newly diagnosed with HIV.

Rates of reported HIV diagnoses, PWA, and deaths among PWA by United Hospital Fund (UHF) neighborhood, New York City 2004¹

	HIV diagnoses ² per 100,000 population	Reported PWA as percent of population	Age- adjusted death rate per 1,000 PWA ³	Population from 2000 Census
Total	45.6	1.2	22.6	8,008,278
Bronx⁴	67.6	1.6	28.8	1,327,690
Crotona – Tremont	82.2	2.1	34.0	199,530
Fordham – Bronx Park	71.1	1.5	25.9	250,491
High Bridge – Morrisania	105.4	2.4	29.4	189,755
Hunts Point – Mott Haven	105.0	2.3	33.2	122,875
Kingsbridge – Riverdale	19.1	0.5	20.0	88,989
Northeast Bronx	33.9	0.8	16.0	185,998
Pelham – Throgs Neck	42.8	1.1	29.6	290,052
Brooklyn⁴	40.2	1.0	27.8	2,465,326
Bedford/Stuyvesant – Crown Heights	88.9	1.8	31.8	317,296
Bensonhurst – Bay Ridge	8.2	0.2	28.7	194,558
Borough Park	11.1	0.3	34.0	324,411
Canarsie – Flatlands	30.3	0.5	24.4	197,819
Coney Island – Sheepshead Bay	13.2	0.4	28.8	286,901
Downtown – Heights – Park Slope	40.5	1.3	23.1	214,696
East Flatbush – Flatbush	56.2	1.1	18.1	316,734
East New York	57.6	1.4	35.1	173,716
Greenpoint	22.5	0.7	24.4	124,449
Sunset Park	24.1	0.6	24.2	120,441
Williamsburg – Bushwick	56.6	1.7	31.1	194,305
Manhattan⁴	62.8	2.0	18.7	1,529,375
Central Harlem – Morningside Heights	119.8	2.6	30.9	151,113
Chelsea – Clinton	151.2	4.4	14.6	122,998
East Harlem	102.7	2.6	27.7	108,092
Gramercy Park – Murray Hill	45.0	1.6	16.1	124,477
Greenwich Village – Soho	63.3	2.3	11.6	83,709
Lower Manhattan	48.6	1.3	21.8	30,895
Union Square – Lower East Side	38.0	1.6	18.7	197,138
Upper East Side	19.7	0.6	11.9	218,167
Upper West Side	29.3	1.4	18.1	222,109
Washington Heights – Inwood	48.4	1.2	17.1	270,677
Queens⁴	24.4	0.6	18.0	2,242,159
Bayside – Little Neck	9.1	0.1	15.2	88,164
Flushing – Clearview	7.0	0.2	20.5	255,542
Fresh Meadows	11.8	0.3	19.9	93,148
Jamaica	42.0	0.9	17.9	285,568
Long Island City – Astoria	30.8	0.7	11.6	220,960
Ridgewood – Forest Hills	11.2	0.4	10.7	240,901
Rockaway	30.0	0.7	20.0	106,738
Southeast Queens	19.1	0.5	21.2	203,670
Southwest Queens	20.0	0.4	22.8	269,952
West Queens	31.8	0.7	19.8	477,516
Staten Island⁴	16.5	0.4	24.3	443,728
Port Richmond	27.1	0.6	24.6	62,788
South Beach – Tottenville	6.1	0.2	30.5	179,892
Stapleton – St. George	32.7	0.7	26.3	116,227
Willowbrook	2.4	0.2	17.1	84,821

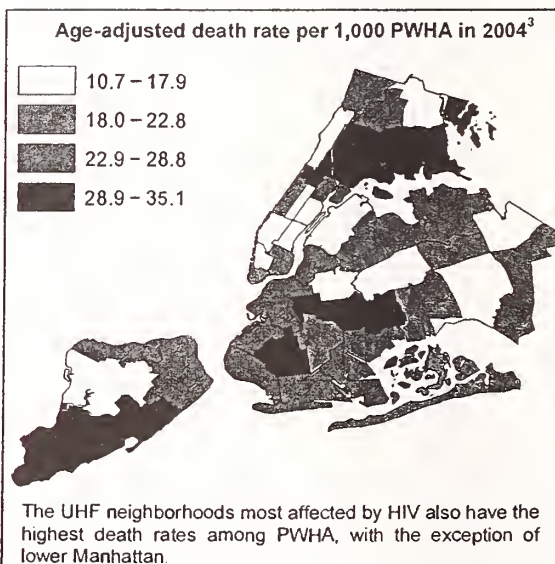
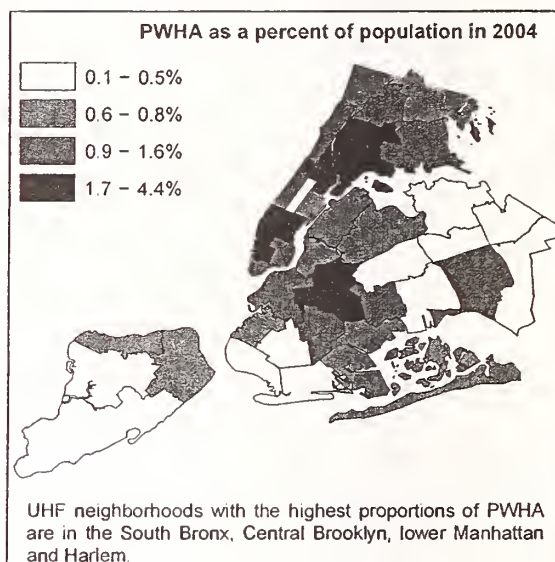
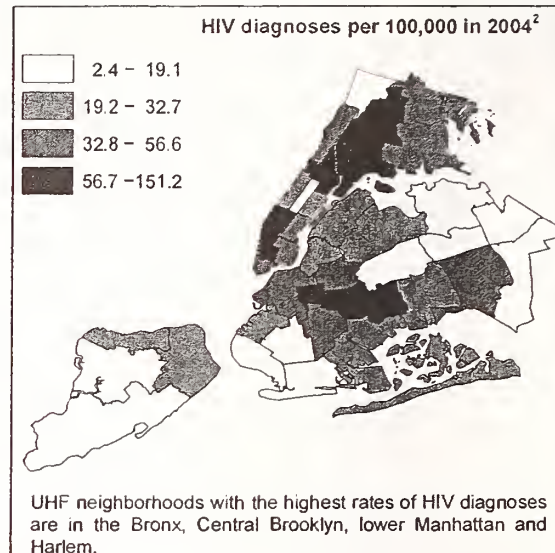
PWA = Persons with HIV/AIDS.

¹ Based on data reported through September 30, 2005.

² Includes diagnoses of HIV without AIDS and HIV concurrent with AIDS.

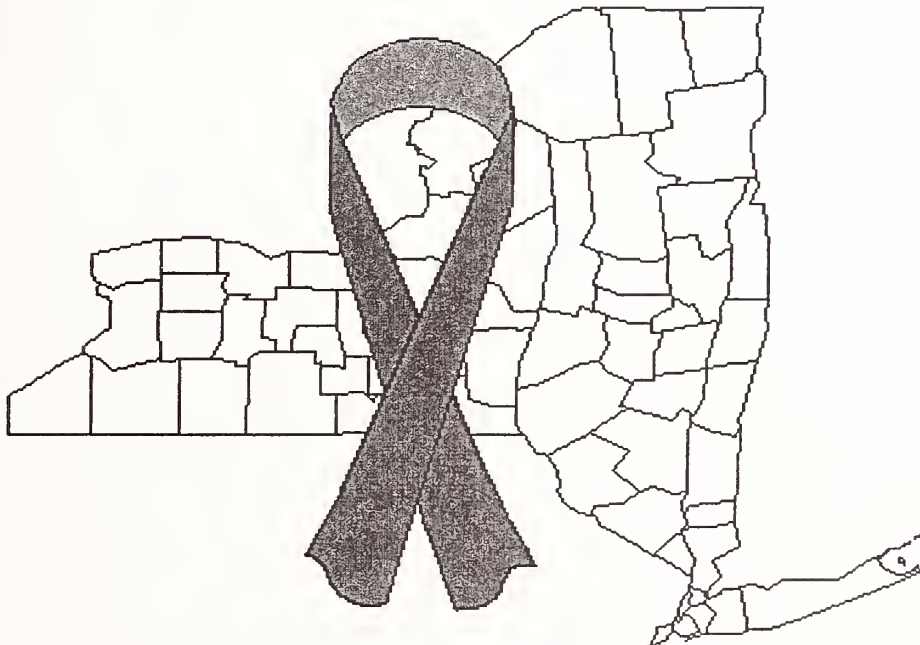
³ Age-adjusted to the city-wide population of PWA at the end of 2004.

⁴ Borough level data include persons residing in unknown UHF neighborhoods.



Question 3:

What are the indicators of risk for HIV infection and AIDS in New York State?



Introduction – Question 3

The materials collected to address the question “What are the indicators of risk for HIV infection and AIDS in the population covered by your service area?” are very different from the materials and information usually included in the Epidemiologic Profile. This section addresses the intersection of HIV risk with culture, lifeways, and nuances of daily living. Not every subpopulation or community is addressed in the following pages. Those that are tell the story of people’s lives and what must take place for HIV prevention to become an expected and routine activity of everyday life.

External Factors

As the PPG membership has become more sophisticated in its approach to the barriers to successful application of HIV prevention activities and techniques at the individual level, four key themes have emerged. The membership has realized that were two individuals of identical risk behavior *and* identical HIV prevention education and training, to be compared, their response to that education and their ability to initiate and maintain prevention activities may differ to the degree that each has or has not experienced poverty, trauma, stigma, and/or relative geographic isolation. While many other differences may also apply, the PPG membership agreed that these four were the components most encountered in their own professional work and, for some, their personal lives.

The following brief discussion of each theme is intended only to raise awareness of the interaction of these experiences with prevention activities. Significant lay and professional literature exists for each topic. Further, previous PPG documents have detailed the work plans, speakers, trainings, and activities undertaken to develop an understanding of the effect of each theme on an individual, couple, group, family and/or community.

The investigation of such themes has long been an activity of the PPG. In previous years, population-based committees have addressed such topics as fetal alcohol syndrome and fetal alcohol effect as a sources of disability in learning/maintaining prevention activities; domestic violence as it relates to partner notification and ability to institute prevention practices; and degree of acculturation as it relates to change in/acquisition of personal risk upon settling in a new country.

Poverty

Numerous theories offer explanations for the relationship of poverty and poor health. As described by Shelley Phipps (CIHI, 2003):

- [a] The *absolute income* hypothesis suggests that health status improves with the *level* of personal income, but at a decreasing rate (Preston, 1975).
- [b] The *relative position* (or *psycho-social*) hypothesis emphasizes individuals' positions within a social hierarchy as a key to understanding the link between inequality in SES (social/economic status) and health (Wilson, Russell, 1996).
- [c] The neo-materialist hypothesis (Lynch, 2000) argues that high levels of income inequality are simply one manifestation of underlying historical, cultural, political, and economic processes that generate inequalities in social infrastructure (such as medical, transportation, educational, housing, parks and recreational systems). From this perspective, inequalities in health derive from inequities in all of the above aspects of the material environment. [1]

Ruby Payne, in Framework for Understanding Poverty, states that people who grow up in poverty learn different things than do people who grow up wealthy or in the middle class. However, most schools and businesses operate with middle-class norms and most teachers and business people grew up learning the 'hidden rules' of middle-class families. With the assistance of a trainer from Ruby Payne's organization, the PPG has integrated an understanding of the effects of poverty on the individual and group into HIV prevention activities. [2]

Reminder from Question 1:

Persons 'living in poverty' are defined as those who earn less than 100% of the Federal Poverty Level (FPL). The FPL is referred to as the poverty threshold. All persons falling below the 200% FPL are considered low income.

The poverty threshold annual income for a family of three was \$14,128 in 2001 and \$14,348 in 2002. [3]

Dr. Payne defines poverty as "the extent to which an individual has access to resources." Before enumerating those resources, she suggests there are key points one must consider in the study of poverty:

- Poverty is relative; if everyone around you is in similar circumstances, it is difficult to discern the boundaries of poor/not poor
- Poverty occurs in all races, ethnicities, and in all countries
- Economic class is a continuum, not a clear cut distinction

- Generational and situational poverty are different: generational poverty is long, often two generations or more as compared to the situational poverty secondary to divorce, death, etc.
- All patterns have exceptions
- An individual brings with her/him the hidden rules of the class in which she/he was raised
- Schools and businesses operate by middle class norms and use the hidden rules of the middle class
- For young people and students to be successful, they must become aware of the hidden rules by which they were raised and must learn the rules that will help them to be successful at school and work
- Teachers and leaders must teach these rules to young people and provide them with help, support, and the expectation that they can master these sets of rules
- To move from poverty to the middle class or from the middle class to wealth, one must give up relationships for achievement – at least for a time

Dr. Payne then goes on to list the resources which, through presence or absence, indicate one's economic level:

- Financial
- Emotional
- Mental
- Spiritual
- Physical
- Support systems
- Relationships/role models
- Knowledge of hidden rules

An individual, living in poverty and attempting to avoid HIV infection may not have the financial means to purchase condoms, male or female, or dental dams. If employed, the person may not have sufficient time away from work to travel to the agencies or locations where free or low cost prevention supplies can be obtained. This same person may also lack a role model for successful self-protection and good decision-making in relationships. The HIV-infected individual bears both the burden of poverty *and* the additional weight of an infectious disease.

References:

References:

- [1] Phipps, S, *The Impact of Poverty on Health: A Scan of Research Literature*, Canadian Institute for Health Information, June 2003.
- [2] Payne, R, Framework for Understanding Poverty, Aha Process, Inc. 2001.
- [3] Kaiser Family Foundation, *State Health Facts Online*, 2004.
<http://www.statehealthfacts.org>

Suggested Activity:

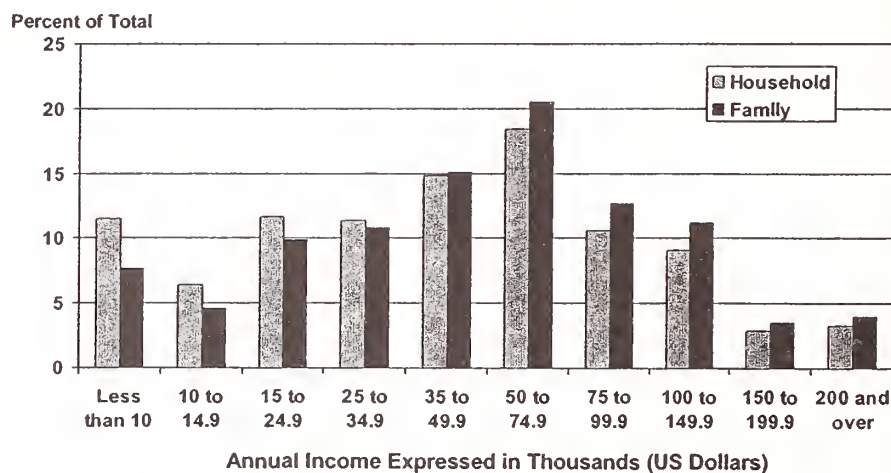
Test Your Knowledge of the Hidden rules of Class: How well could you survive?
A test from: Payne, R, Framework for Understanding Poverty, Aha Process, Inc. 2001.
<http://www.Ahaprocess.com>

US Census Bureau Definitions of “Household” and “Family”

- A household consists of all the people who occupy a housing unit. A house, an apartment or other group of rooms, or a single room, is regarded as a housing unit when it is occupied or intended for occupancy as separate living quarters; that is, when the occupants do not live and eat with any other persons in the structure and there is direct access from the outside or through a common hall.
- A family is a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.

Distribution of Household and Family Income in NYS

US Census Bureau – Census 2000



Trauma

A personal experience of trauma, particularly psychological but also including physiological experiences early in life, appears to impact an individual's ability to protect himself or herself from HIV transmission and, when infected, to implement and maintain practices that will block transmission to others. The degree to which any one individual can access, learn, and employ HIV prevention practices and obtain appropriate health care may well be in reverse proportion to a historical or current experience of trauma.

Trauma is defined as the personal and subjective experience of an individual that is so stressful that:

- "The individual's ability to integrate his/her emotional experience is overwhelmed, or
- The individual experiences a threat to life, bodily integrity, or sanity." [1]

The traumatic event or series of events can take many forms:

- One-time incidents, e.g. accidents, natural and technologic disasters, crime
- Chronic or repetitive incidents, e.g. child abuse, war, urban violence, domestic violence, long-term deprivation
- Medical or health-based incidents, e.g. receiving a diagnosis of HIV/AIDS
- Incidents involving a single individual
- Incidents involving large numbers of individuals, families, social networks, and/or communities
- Symptoms may be immediately manifest
- Symptoms may be delayed
- Symptoms may resolve with or without treatment
- Symptoms may become chronic even with support and treatment
- Symptoms may be psychological, physiological, and/or emotional in nature
- Symptoms may also occur in the witness of trauma to another person or in a family member of a victim

Those with a history of trauma may be unable to trust others, see the world as a safe place, or avoid further exploitation. They may have poor or near absent coping skills and be unable to make decisions through organized, rational thought. Depression, anxiety, paranoia, and/or other mental health conditions may additionally hamper decision-making efforts. [2]

Prevalence of trauma in the general population was estimated in 1995 using data from the National Comorbidity Study of the National Institutes of Health. Sixty percent of men and 51% of women reported at least one episode; 17% of men and 13% of women who had experienced trauma "had actually experienced more than 3 such events." [3]

- [1] Pearlman LA and Saakvitne KW, *Trauma and the Therapist*. New York, Norton, 1995.
- [2] Giller E and Vermilyea E, *About Trauma*,
<http://www.sidran.org/whatistrauma.html>.
- [3] Kessler RC, A Sonnega, and E Bromet, Posttraumatic stress disorder in the National Comorbidity Study. *Archives of General Psychiatry*. Vol. 52, 1048-1060.

Rural Life and HIV/AIDS in NYS

As of December 1999 there were 43,000 people living with AIDS in small towns and rural communities of the United States [Associated Press, 1998]. Between 1991–1995 rural areas with less than 50,000 persons experienced the highest growth rate of AIDS cases (80%) followed by a 64% growth rate of AIDS cases in small metropolitan areas with 50,000–500,000 persons. [Rural Center AIDS & STD Prevention, 1996]. A 1994 report of all AIDS cases in all U.S. counties cited that the top 25 counties experiencing rapid increases in AIDS cases were predominately rural [Lam et al., 1994].

There is enormous variation among New York State's nonmetropolitan communities in terms of population density and composition, geography, climate, transportation, fiscal resources, service infrastructure and proximity to cities. These differences are found even within a given county or town. Some rural areas of New York State have transient and mobile populations such as migrant farm workers, seasonal resort workers, tourists, university faculty and students. Further, many upstate residents are "snowbirds" as they winter over in warmer states such as Florida and California. This means these vacationers are at risk in both their summer and winter locations and, if infected, can carry the infection from one location to another. Just as during prohibition, the drug trade relies heavily on people who travel throughout upstate New York to and from larger metropolitan areas. Upstate New York also includes twelve Native American reservations, numerous correctional facilities and is home to several international border crossings to Canada.

New York State's rural communities can provide their residents both strong support and strong condemnation at times. In rural areas, traditional moral values, conformity to community norms and intolerance of diversity can be strong. In some cases, homophobia, racism, sexism and stigmatization of people with AIDS, homosexuals, minorities and drug users makes HIV prevention extremely challenging. The following are some of the unique challenges facing New York State's rural communities:

Confidentiality and anonymity can be hard to maintain in urban areas and especially challenging in rural communities. Testing for HIV, discussing sexual practices with clinicians, obtaining drug treatment, or buying condoms in local stores can be difficult to do confidentially in rural areas. The "*close-knit*" quality and the impression that "*everyone knows each other*" enables people to work more effectively together to solve problems but often times at the price of confidentiality and anonymity. Some researchers believe that HIV rates in rural areas are higher than reported because rural residents, concerned about confidentiality travel to larger cities for anonymous testing and give false addresses [New York AIDS Coalition, 1999].

Traditionally, lower priority has been given to rural and non-urban areas due to lower density of population and therefore to lower case numbers of HIV/AIDS. However, to continue with this view would create a reservoir of infection that could then repopulate cases in other areas if not addressed.

Numerous rural residents are under the erroneous notion that HIV/AIDS is not a problem in rural, suburban and small urban communities in upstate New York and Long Island, particularly if they are not homosexual nor intravenous drug users. Denial is fueled by the stigma surrounding HIV and these high-risk groups because infected individuals living in these communities are less likely to reveal their HIV status to others. The common perception by residents of rural and suburban communities is that they are relatively free from the problems normally associated with the risk of HIV infection.

Health care providers and county health departments are often the source for health education and prevention counseling in rural areas. Agencies providing HIV/AIDS education and support are often full service organizations where HIV/AIDS is not their primary activity. While on one hand this is helpful as it protects confidentiality, on the other hand it makes HIV/AIDS services difficult to find unless you are familiar with the community. It also results in non-prioritization of HIV when other needs may seem more urgent or when an agency is criticized for being involved with AIDS. Also, rural clinicians may believe that HIV is not a problem in their area, which can result in improper risk assessment and diagnosis as they may not even mention it to their patients. Rural health care providers are also burdened by the migration patterns resulting in more HIV-positive patients returning home or moving to smaller towns and rural areas from large urban centers and the shortage of rural-based medical and mental health professionals experienced in HIV/AIDS prevention and care.

Throughout New York State, both poverty level communities and large employers are transferring their medical care to HMO systems. This is particularly difficult in rural areas where the consolidation of care in one or two HMOs means both a decrease in no-HMO alternatives and, as has happened recently, vulnerability for large segments of the rural population if an HMO stops servicing an area or moves out of New York State. Certain HMOs, due to their design and style of management, have been less than proactive in participating in certain public health activities such as: treatment of STDs and reporting certain laboratory values to state, thus depriving rural areas of important health data.

New York State's various geographic and climatic conditions can hinder access to preventative services and care. Many rural communities have limited or no public transportation systems. For those with access to other modes of transportation, severe winters, vast geographic distances, the lack of HIV/AIDS trained professionals and confidentiality concerns can mean traveling several hours in order to access HIV primary prevention, educational programs, testing, supportive services or care. There is often confusion about where to go for care. For example, an individual living in Franklin County, NY who needs medical center-level care is, by road, approximately 1 hour from both Burlington, Vermont, and Montreal, Quebec, Canada, but is 3½ -4 hours from Albany, New York, where the designated medical center for Northern New York is located.

Many people living in rural communities still lack the knowledge of how HIV is contracted and the presence of the disease in their communities. Interviews with HIV-infected patients in rural areas of four states showed that more than half never thought they were at risk of contracting HIV though most were engaging in unprotected sex and other risky behavior. Thirty-three percent of men and 29% of women admitted they had no idea how the virus was spread [Associated Press, 1998]. People living in rural communities appear to still hold the perception

that they are not at risk for HIV if they do not use IV drugs, are not homosexual and do not reside in a large city. They tend to think they are protected simply because of where they live. This can be reinforced when physicians do not routinely discuss HIV prevention and risk reduction with their patients.

It is certainly apparent that HIV-infection has emerged and will continue to grow in the towns, villages, small communities and cities outside of the AIDS epicenter of New York City. Although these communities share similarities with their large urban neighbor, the differences and unique challenges are as diverse as the residents of the entire State of New York.

References:

Keiner A, Siebold-Simpson S, and St. Hilaire M, *HIV/AIDS and Rural Communities*, New York State HIV Prevention Planning Group, Emerging Issues Committee, 2002.

AIDS NETWORK OF WESTERN NEW YORK (1999). Survey results of persons living with HIV/AIDS in Western New York State. *AIDS Network of Western New York*.

ANTHONY, T. (1993). AIDS in rural America bares fear, ignorance. *Associated Press*. Hinton, VA.

ASSOCIATED PRESS (1998). CDC: Many rural Americans ignorant about HIV. *CNN Interactive*, <http://www.cnn.com>.

ASSOCIATED PRESS (2000). Audit: rural AIDS funds lacking. *Journal Sentinel Online*, <http://www.jsonline.com>

CENTER FOR AIDS PREVENTION STUDIES-A Research Initiative (1997). What are rural HIV prevention needs. *University of California at San Francisco-UCSF*, <http://www.ucsf.edu>.

CENTERS FOR DISEASE CONTROL AND PREVENTION *HIV/AIDS Surveillance Reports*, <http://www.cdc.gov>.

CENTERS FOR DISEASE CONTROL AND PREVENTION (1998). *National AIDS Clearinghouse*, <http://www.cdcnac.org>.

CRANE, M. (2001). Living with HIV harder in rural areas. *The Columbus Dispatch*, June 3.

CROSBY, R., et al. (2000). Rural and non-rural adolescents HIV/STD sexual risk behaviors: comparison from a national sample. *RAP Time*, 5(1): 2.

DECARLO, P. (1998). What are rural HIV prevention needs? *AIDSLine-WORLD*, 82(7).

DICLEMENTE, R. (1993). Comparison of AIDS knowledge and HIV related sexual risk behavior among adolescents in low & high AIDS prevalence communities. *Journal of Adolescent Health*, 14(3): 231/236.

FISHER, J., D. WILCUTTS, et al. (1998). Dynamics of sexual risk behavior in HIV-infected men who have sex with men. *AIDS & Behavior*, 2: 101/113.

HECKMAN, T., A. SOMLAI, et al. (1998). Psychosocial differences between urban & rural people with HIV/AIDS. *Journal of Rural Health*, 14(2): 138/145.

HECKMAN, T., A. SOMLAI, et al. (1998). Health related quality of life among people living with HIV disease in small communities and rural areas. *Psychology & Health*, 13: 859/871.

HECKMAN, T., A. SOMLAI, et al. (1998). Barriers to care among persons living with HIV/AIDS in urban and rural areas. *AIDS Care* 10(3): 363/375.

HECKMAN, T., J. KELLY, et al. (1999). Sexual behavior among persons living with HIV disease in small towns and rural areas. *Journal of Sex Education & Therapy*, 24(1&2): 29/36.

HECKMAN, T., S. KALICHMAN, et al. (1999). A telephone-delivered coping intervention for persons living with HIV and AIDS in rural areas. *Social Work with Groups*, 21(4): 49/61.

HECKMAN, T. (2000). Addressing the mental health needs of HIV infected rural residents. *WNY Rural Summit* - Batavia, NY.

HOBBS, D. (1995). The context of rising rates of rural violence and substance abuse: the problems and potential of rural communities. *North Carolina Regional Educational Laboratory-Pathways*, <http://www.ncrel.org>.

KAISER FAMILY FOUNDATION (1999). HIV rate far from manageable. *St. Petersburg Times*. St. Petersburg, FL: 2/12.

KIENER, A. (1998). Migrant farmworkers: the invisible & forgotten among us. *Network News* 4(7): 3.

KLEIN, S., NOKES, K., et al. (2001). Age appropriate HIV prevention messages for older adults: Findings from focus groups in New York State. *J Public Health Management Practice* 7(3): 11/18.

KLETECKA, C. (1998). Country living with AIDS. *Body Positive*, 11(12).

LAM, N. AND K. LIU (1994). Spread of AIDS in rural America. *Journal of Acquired Immune Deficiency Syndromes* 7: 485/490.

LEUKFELD, C., R. CLAYTON, et al. (1992). "Rural drugs and alcohol treatment." *Drugs & Society* 7: 95/116.

LUNA, G. (2001). Suburban and rural populations. *Body Positive*, 14(2).

MORBIDITY AND MORTALITY (1998). Risks for HIV infection among persons residing in rural areas and small cities. *MMWR Weekly*, 47(45): 974/978.

NATIONAL RURAL HEALTH ASSOCIATION (1995). HIV/AIDS in rural America, *National Rural Health Association*, <http://www.nrharural.org>.

NEW YORK AIDS COALITION – NYAC (1999). HIV in New York State's rural, suburban & small urban areas: an assessment of prevention needs & responses. *NYAC*.

ROBERTS, T. (1995). Rural outreach AIDS project. *New England Sounding Line*, 1(5).

ROTHENBERG, R., C. STERK, et al. (1995). Using social network and ethnographic tools to evaluate syphilis transmission. *Sexually Transmitted Diseases*, 25(3): 154/160.

RURAL AIDS ACTION NETWORK - RAAN, (2001). Profile – prevention planning project: youth at risk. *School Health Opportunities and Progress (SHOP Talk)* – *SIECUS*, www.siecus.org/pub/shop.

RURAL CENTER AIDS & STD PREVENTION (1996). HIV/AIDS in rural America. *RCAP-Fact Sheet*, Number 8.

RURAL CENTER AIDS & STD PREVENTION (1997). Developing rural HIV/STD prevention education programs. *RCAP-Fact Sheets*, Number 10.

SCHMITT, E. (1989). AIDS stretches limits of rural health care. *New York Times*, B1.

SIERRA FOOTHILLS AIDS FOUNDATION. (1996). Delivering services to the rural HIV community: special problems exist. *Sierra Foorhills AIDS Foundation*. <http://www.nccn.net/~aidsfoun/rural.htm>.

WASHINGTON POST (1997). National special report: the new world of AIDS: stopping the virus, *WashingtonPost Online*, <http://www.digitallibrary.com>

Stigma

“AIDS patients suffer in two basic ways. We suffer from a life-threatening illness, and we suffer the stigma attached to being diagnosed with AIDS.”

Michael Callen (1955-1993)

Remarks to the New York State Congressional Delegation, 1983

* * * * *

The word “stigma” has roots in Greek where it referred to marks or signs on the body designed to expose something unusual and bad about the moral status of the bearer. The meaning has been modified through the centuries and today, as applied to HIV/AIDS, “refers to prejudice, discounting, discrediting, and discrimination directed to people perceived to have AIDS or HIV, and individuals, groups, and communities [with] which they are associated.” [1]

Stigma presents as the psychological attitude of an individual, of public opinion, and/or as the collective conscience. Stigma in one setting, for example: racism, is often layered with other ‘isms’ and phobias, for example: racism and xenophobia (fear, dislike, and/or mistrust of foreigners or things foreign). Such beliefs and attitudes are associated with age, education, and contact with persons of the stigmatized group.

In the arena of HIV/AIDS, the impact of stigma affects prevention, intervention and care through various channels including but not limited to:

- Perpetuates misinformation about HIV transmission and ‘contagion by association’
- Decreases effectiveness of counseling, testing, and referral programs
- Deters critical access to health care and treatment
- Inhibits disclosure of HIV status to sex or drug-using partners and/or use of safer sex/safer drug use practices for fear of appearing to be HIV positive
- Delays behavior change
- Leads to social isolation and self-destructive attitudes and behaviors
- Undermines personal, family, and community support networks

Individually or as a group, persons living with HIV/AIDS can, due to stigmatization, suffer loss of employment, eviction and/or lack of access to adequate housing, denial of health care and/or supportive services, expulsion from educational facilities, denial of participation in social and recreational events and activities, involuntary and non-consensual testing and HIV-specific restrictive laws, harassment, violence and death. [2]

[1] Herek GM, "AIDS and Stigma," *American Behavioral Scientist*, 42(7):1106-16, 1999.

[2] Karchner W, SJ Klein, and DA O'Connell, "Addressing HIV-related Stigma and Discrimination in NYS: The Role of the AIDS Institute," Presentation to HEPI610: HIV/AIDS Epidemiology, School of Public Health, State University at Albany, Rensselaer, NY, December 1, 2003.

Key Populations of NYS:

Men Who Have Sex With Men (MSM)

Injection Drug Users

Heterosexuals

**Children at Risk of
Mother-to-Child-Transmission**



Men Who Have Sex With Men (MSM)

NB: In this discussion MSM includes MSM/IDU (those men who have sex with men and who also inject drugs).

The pandemic now known as HIV/AIDS was first recognized among MSM in the greater Los Angeles area. Since then, in most regions of the US, MSM represent the majority of those who now live with or have died from HIV infection. New York State, however, has a very different profile, with MSM representing 31% of cumulative cases of AIDS, primarily due to the large proportion of injection drug-related infections. Still, New York's 50,127 AIDS cases among MSM account for over 10% of the cumulative cases among MSM in the US.

Percent MSM (including MSM/IDU) Among Transmission Categories

	United States ¹	New York ²
Cumulative AIDS Cases	54	31
Persons Living with AIDS	51	27
New AIDS Cases Diagnosed in 2003	46	24

¹Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report: 2003*

²NYSDOH, *New York State HIV/AIDS Surveillance Semiannual Report: 2003*

The major sexual risk for MSM, including the 9.4% who inject drugs, is unprotected anal intercourse (UAI). Other practices, such as unprotected oral-penile, oral-anal and oral-oral contact also confer risk of HIV transmission, albeit at a lower level. Any 'sexual subpopulation' behavior which exposes participants/partners to blood and genital fluids would, likewise, be of risk. Of recent interest is the use of "crystal" (crystal methamphetamine) and its relationship to HIV transmission among MSM. [Drug injection-related risk and the risk of substance use is discussed in an upcoming section.]

The 20-plus years of HIV behavioral research has shown that the personal recognition of HIV-related risk is based on a myriad of psychological, social, cultural, religious, subculture, educational, self-worth, and other personal values and beliefs. Likewise, the ability of an individual to institute -- and to maintain--protective behaviors is affected by all of the factors listed above and these factors as they dictate the behaviors of a sexual partner or partners. Intoxication through drugs or alcohol makes the task of behavior change and maintenance even more difficult.

In the recent past, studies have added to the understanding of HIV risk and harm reduction and, for the individual who is HIV-infected, an understanding of the personal burden of adherence to medication dose and schedule.

Selected study findings, and potential next steps, include:

- Rates of distress and depression are high among MSM: the 7-day prevalence of depression was 17.2% higher among MSM than in adult US men in general
 - Predictors of distress and depression may assist in design and application of more effective HIV prevention efforts. [1]
- Psychosocial health problems, HIV high-risk behaviors, and living with HIV infection were significantly and positively associated in a telephone survey of MSM conducted in New York, San Francisco, Los Angeles, and Chicago.
 - HIV prevention may be enhanced by addressing broader health concerns of MSM *and* sexual risk. [2]
- In a sample of MSM from New York, Los Angeles, Chicago, and San Francisco, HIV prevalence was 19% for men in their 50s and 3% for those in their 60s. No men in their 70s were found to be HIV+. Prevalence was higher among older, Black MSM (30%), MSM who also injected drugs (21%), moderately heavy drug users (35%), and less closeted men (21%). High-risk sex between discordant partners was relatively consistent among MSM in age groups above 30 (4-5%) then decreased among those in their 70s. The high mortality prior to HAART availability may account for the lower levels of HIV among MSM in their 60s and 70s.
 - Given the effect of HAART in greatly extending the active years of life for HIV-infected MSM since 1997 and the high level of risk behaviors among MSM in their 60s, the investigators expect an older MSM epidemic of larger proportion than that of the 1980s and 1990s. [3]
- In a multi-city (New York, San Francisco, Los Angeles, and Chicago) study of MSM, 21% had made a suicide plan and 12% had attempted suicide. Of those making an attempt, nearly one half were multiple attempters. Most first attempts were made prior to age 25. Average age at first attempt has decreased over time.
 - Some risk factors for suicide attempts are specific to being gay or bisexual in a hostile environment. [4]
- In a multi-city (New York, San Francisco, Los Angeles, and Chicago) urban study of MSM, recreational drug use was reported by 52% of respondents, alcohol use by 85%, and multi-drug use by 18%. Further, 12% reported 3 or more alcohol-related problems, 19% frequent drug use, and 8% heavy-frequent alcohol use. Associated with heavy-frequent substance use was adverse early life circumstances, current mental health status, social and sexual practices, and connection to the gay male culture.
 - This complex pattern suggests that frequent-heavy substance use is grounded at multiple levels: individual, interpersonal, and socio-cultural (community). [5]

- Men living in “gay ghettos” areas of highest concentration of MSM, in New York, San Francisco, Los Angeles, and Chicago, differ from those who live elsewhere in the urban setting: non-ghetto dwelling MSM were less involved in the gay and lesbian community, were less likely to have only male sexual partners, less often identified as gay, and were less likely to have been tested for HIV.
 - Prevention efforts and health care planning must take into consideration these differences. [6]
- Among MSM in New York, San Francisco, Los Angeles, and Chicago, the link between sexual risk-taking and the prevalence and characteristics of childhood sexual abuse (CSA) was explored in a telephone survey. Twenty percent of participants reported CSA primarily by non-family perpetrators. Initial CSA experiences were characterized by high levels of force: 43% involved physical force/weapons and 78% penetrative sex. Forty-six percent reported attempted or actual anal intercourse.
 - The high rise of CSA among MSM, which can predispose such men to patterns of sexual risk, warrants new approaches to HIV prevention. [7]
- The level of new HIV infections among young black MSM is among the highest of all groups at risk in the US. Among the 16% of young black MSMs participating in the Young Men’s Study (YMS) who were found to be HIV positive, almost all were unaware of their status. [8]
 - Where possible, rapid testing and/or venue-based testing coupled with culturally appropriate testing messaging may contribute to increasing numbers of young black MSM testing for HIV and STDs and receiving their result.
- Of the 920 black MSM, 585 (64%) had ‘ever’ tested previously for HIV. The 332 black MSM not tested previously gave the following reasons for not seeking HIV counseling and testing: low personal risk of infection (45%); fear of learning the result (41%); and fear of needles (21%). The reasons given for not using a condom during sexual contact included: they “knew” their partners were HIV negative, and/or they thought their partners were at very low risk; and/or condoms were unavailable at the moment of sexual contact. [8]
 - Activities to reduce HIV-related stigma and to address confidentiality and fear concerns may contribute to increasing initial testing, and for persons receiving negative results, frequent retesting.
- Unprotected anal intercourse (UAI) was studied among 91 concordant (same HIV status) HIV positive couples in primary partner relationships in New York City and San Francisco. The findings indicate unprotected anal intercourse is common among concordant couples and can compromise their health through superinfection/reinfection even when both partners are monogamous. If monogamy is not maintained, other STDs may also be transmitted between primary partners. [9]
 - Public health messages explaining superinfection have been disseminated by health care providers. These same messages, if included in prevention materials and information, may increase awareness among concordant positive primary partners.

Crystal Methamphetamine Use

- Methamphetamine use has recently been implicated as contributing to high risk sexual behaviors of gay men, particularly those who frequent bars, sex clubs, and the “circuit” parties. This drug and its related substances, amphetamine and MDMA (ecstasy), have been available for many years, but recent reports indicate a widespread increase in use across the country, from the West to the East.
- Two informative papers by Perry Halkitis and his colleagues [10,11] provide a level of understanding of the chemical makeup, routes of use, and conditions brought about by use of methamphetamine, and further explore the social context of current ‘epidemic’ usage among gay and bisexual men in New York City. These articles are referenced below.

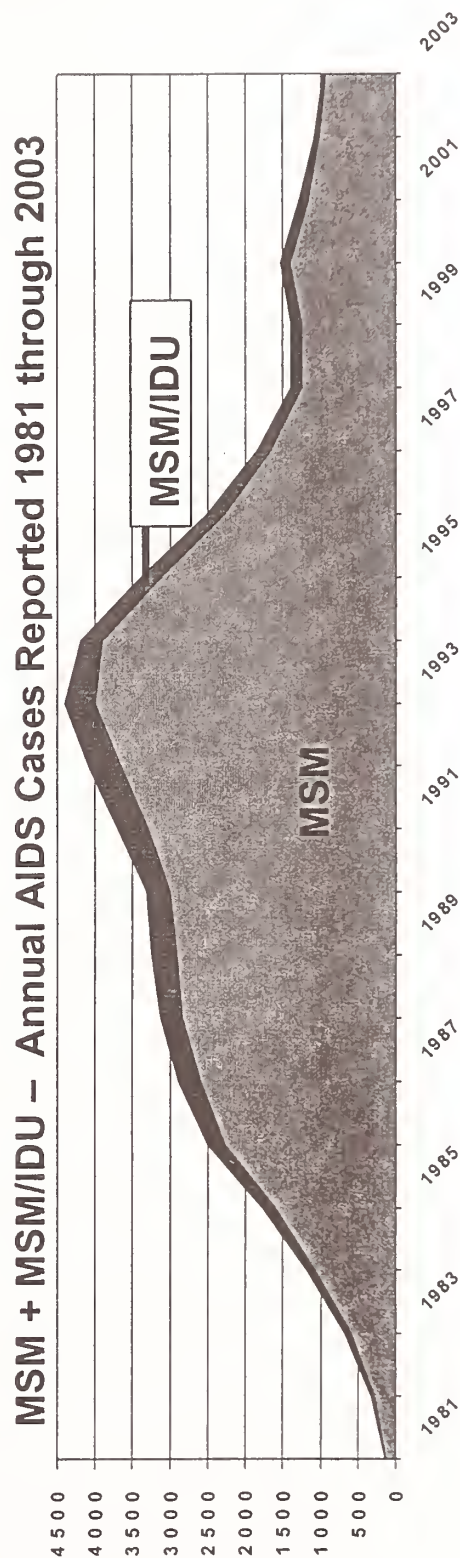
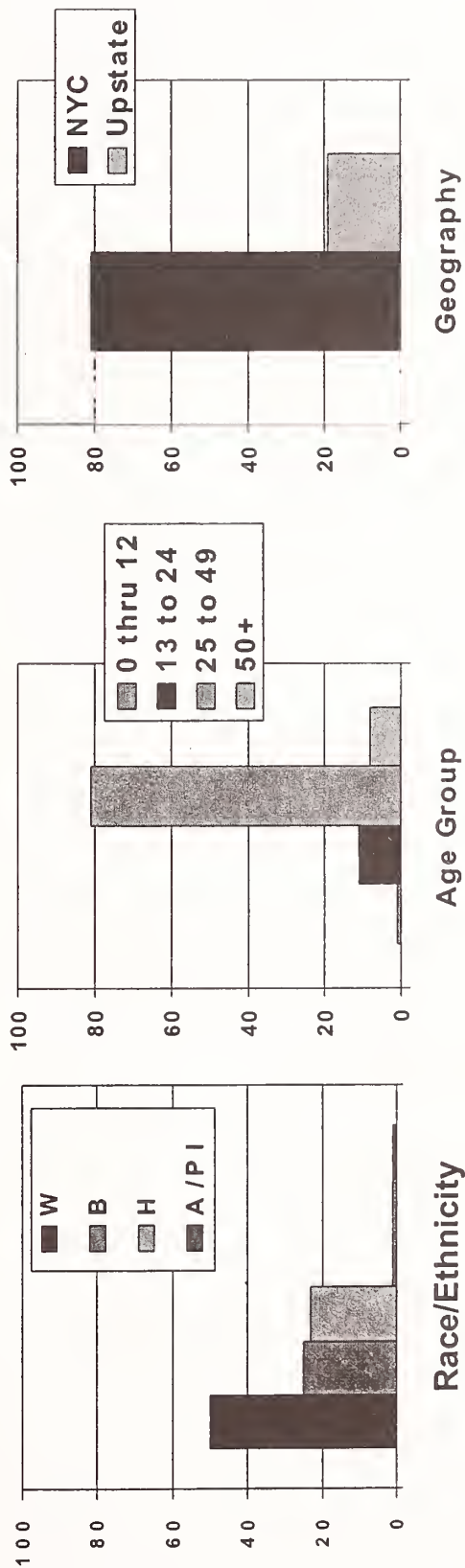
Intentional Unsafe Sex (Barebacking)

- Since the mid-1990s, the emergence of relatively high levels of intentional unsafe sexual practices, i.e. barebacking (unprotected anal intercourse among MSM), has been of concern. Some have suggested that the availability of HAART and the resultant active lifestyle led by individuals taking these combination medications has, in fact, contributed to the return to unsafe behavior.
 - Three studies [12, 13, 14] address the nature of and reasons for intentional unsafe sex among gay and bisexual men and MSM. These articles are referenced below.

MSM and MSM/IDU

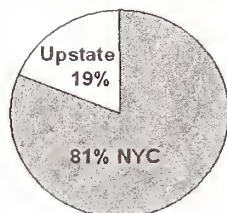
Data Through December 31, 2003

HIV (not AIDS) Cases Reported from June 1, 2000 - December 31, 2003 – by Percent



Cumulative AIDS Cases in NYS

There have been a total of 157,776 AIDS cases diagnosed among New York State residents through December 2002

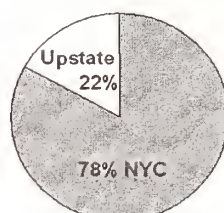


127,608 were residents of NYC and 30,168 resided in Upstate NY at time of diagnosis

Data complete through 2002
BHA/E/NYSDOH

Males Living with HIV/AIDS in NYS

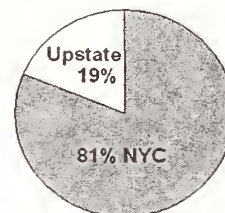
There are 64,228 Males Living with HIV/AIDS in New York State as of December 2002



49,798 were residents of NYC and 14,430 resided in Upstate NY at time of diagnosis

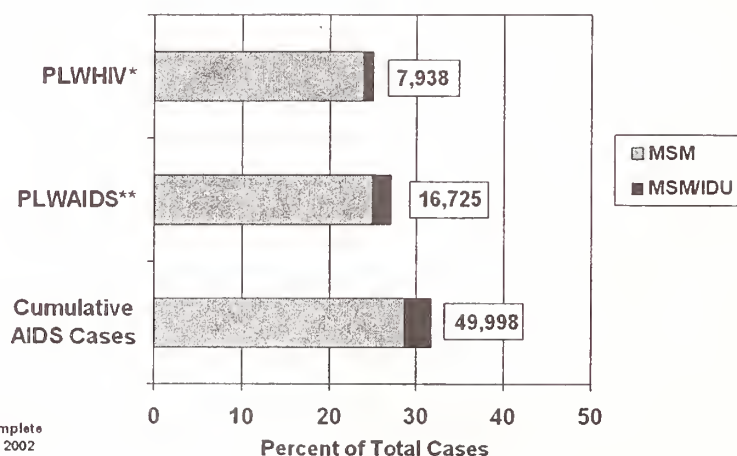
MSM&MSM/IDU Living with HIV/AIDS in NYS

There are 24,501 MSM & MSM/IDUs Living with HIV/AIDS in New York State as of December 2002



19,762 were residents of NYC and 4,739 resided in Upstate NY at time of diagnosis

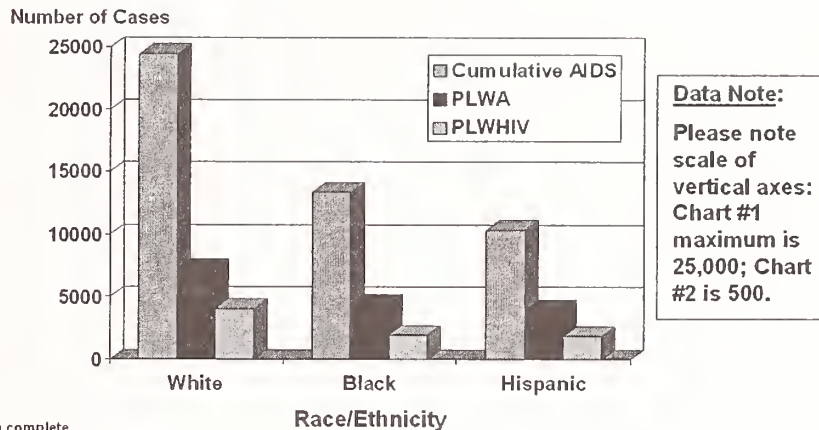
The Proportion (Number) of MSM & MSM/IDU among Cumulative AIDS Cases and those Persons Living with HIV* and with AIDS**



Data complete through 2002
BHA/E/NYSDOH

Cumulative AIDS Cases, Persons Living with AIDS (PLWA), and Persons Living with HIV (PLWHIV) among MSM & MSM/IDU in NYS by Race/Ethnicity

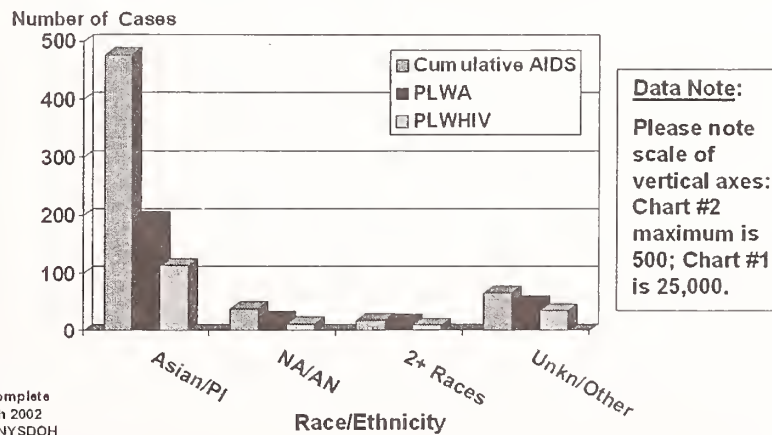
Chart #1: White, Black, Hispanic



Data complete through 2002
BHAE/NYSDOH

Cumulative AIDS Cases, Persons Living with AIDS (PLWA), and Persons Living with HIV (PLWHIV) among MSM & MSM/IDU in NYS by Race/Ethnicity

Chart #2: Asian/Pacific Islander (A/PI), Native American/Alaskan Native (NA/AN), Persons of 2+ Races, Unknown/Other



Data complete through 2002
BHAE/NYSDOH

References

- [1] Mills TC, Paul J, Stall R, et al., "Distress and depression in men who have sex with men: the urban men's health study," *Am J Psychiatry*. 2004 April 161(4): 776.
- [2] Stall R, Mills TC, Williamson J, et al., "Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men," *Am J Public Health*. 2003. Jun; 93(6):939-42.
- [3] Dolcini MM, Catania JA, and Pollack L, "The HIV epidemic among older men who have sex with men," *J Acquir Immune Defic Syndr*. 2003 Jun1: 33 Suppl 2:S115-21.
- [4] Catania JP, Pollack L, Moskowitz J et al., "Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents," *Am J Public Health*. 2002 Aug: 92(8):1338-45.
- [5] Stall R, Paul JP, Greenwood G, et al., "Alcohol use, drug use and alcohol-related problems among men who have sex with men: the urban men's health study," *Addiction*. 2001 Nov; 96(11): 1589-601.
- [6] Binson D, Woods WJ, Pollack L et al., "Health-related characteristics of men who have sex with men: a comparison of those living in "gay ghettos" with those who live elsewhere," *Am J Public Health*. 2001 Jun; 91(6): 980-3.
- [7] Paul JP, Catania J, Pollack L and Stall R., "Understanding childhood sexual abuse as a predictor of sexual risk-taking among men who have sex with men: the urban men's health study," *Child Abuse Negl*. 2001 Apr; 25(4): 557-84.
- [8] Bingham T, McFarland W, Shenan DA et al., "Unrecognized HIV infection, risk behaviors, and perceptions of risk among young black men who have sex with men-- six US cities, 1994-1998. *MMWR*. Centers for Disease Control and Prevention. 2002 August 23; 51(33): 733-736.
- [9] Halkitis PN, Wilton L, Parsons JT, and Hoff C, "Correlates of sexual risk-taking behavior among HIV seropositive gay men in concordant primary partner relationships," *Psychology, Health, and Medicine*. 2004 Feb; 9(1) 99-113.
- [10] Halkitis PN, Parsons JT, and Stirratt MA, "A double epidemic: crystal methamphetamine drug use in relation to HIV transmission among gay men," *Journal of Homosexuality*. 2001; 41(2) [17-35].

- [11] Halkitis PN, Parsons JT, and Wilton L, "An exploratory study of contextual and situational factors related to methamphetamine use among gay and bisexual men in New York City," *Journal of Drug Issues*. 2003 Spring; 33(2), 413-432.
- [12] Hart T, Peterson JL et al., "Predictors of risky sexual behavior among young African American men who have sex with men," *Am J Public Health*, Jul 2004; 94: 1122 - 1124.
- [13] Halkitis PN, Parsons JT, "Intentional unsafe sex (barebacking) among HIV positive gay men who seek sexual partners on the internet," *AIDS Care*. 2003 June; 15 (3): 367-378.
- [14] Halkitis PN, Parsons JT, Wilton L, "Barebacking among gay and bisexual men in New York City: explanations for the emergence of intentional unsafe behavior," *Archives of Sexual Behavior*. 2003 Aug; 32 (4): 351-357.

Injecting Drug Users

Individuals who inject drugs are at risk of acquiring HIV through three routes: (1) the actions of injection whereby HIV can be introduced directly into the bloodstream, (2) sexual contact with body fluids of an infected partner, and (3) due to intoxication from alcohol and/or injected/non-injected drugs, the inability to institute or maintain safer injection and sexual techniques.

Sexual risk in the absence of injection drug use is discussed elsewhere in this document (see Heterosexuals, immediately following on page 3-36) and applies to injectors as well as non-injectors. It has long been assumed that in the presence of both injection and sexual risk that injection was more likely to transmit HIV. However, Strathdee and colleagues have recently reported that “high-risk sex is the main factor in HIV infection for men and women who inject drugs.” [1]

Among men who injected drugs during the study observation period, new HIV infection (incidence) was 10.44% a year for those who had been homosexually active in the most recent six months but only 3.01% among those who were not. Among women, high risk heterosexual activity was the main predictor of seroconversion. [1]

NIDA (National Institute of Drug Abuse) has recommended that an injector follow this hierarchical protocol:

- Stop injecting drugs/stop using drugs.
- Enter and complete drug treatment, including aftercare/relapse prevention programs.
- If you continue to inject drugs, take the following steps to reduce personal and public health risks:
 - Never reuse or share syringes, equipment, water, etc.
 - Use only new syringes from a pharmacy or syringe exchange program (SEP). Do not trust those sold on the street as they may be repackaged, used syringes.
 - Always use a sterile, new syringe to prepare, measure, and inject drugs.
 - Use sterile water to prepare drugs for injection. If not available, use a clean, reliable, drinking water supply (Example: Never use water from a toilet bowl; use the clean water in the tank).
 - Always use a new, clean cooker and cotton (filter) to prepare and to load drugs. Never reuse a cotton; it cannot be cleaned. A cooker can be disinfected if necessary.
 - Use alcohol or, if not available, soap and water to cleanse your injection site. Let air dry.

- Safely dispose of syringes after one injection: use community sharps disposal sites, usually at local hospitals, or check with your nearest SEP. [2] [3]

Understanding the context in which IDUs (injection drug users) obtain and use drugs is vital to design and deployment of prevention and intervention programming. Koester and colleagues have looked at drug sharing among injectors as “a process” rather than as individual behavioral steps. In an effort to identify points in the procedure of drug sharing, these investigators found that IDUs who were dopesick and those who injected in unsafe* environs were most likely to skip a protective step or to reuse injection equipment. Those who injected in an unsafe setting were almost three times as likely to share uncleaned, used cookers. When at least one injector in the group is dopesick**, there is two times the risk of using an unclean syringe as compared to those injecting in a safe environment. [4]

The utilization of SEP or pharmacy-obtained syringes addresses the issue of sterile syringe access but few, if any, programs currently address the inherent environmental and social risk of injection in an unsafe setting. The issue of an injector being dopesick at the time of injection raises further questions concerning intervention in transmission of HIV and other blood-borne illnesses.

* Definition: An unsafe setting is one where the person or persons injecting may be subject to any or all of the following:

Environmental:

- Out-of-doors; subject to bad weather.
- Inadequate lighting; visible to others.
- Absence of clean water; clean surface.
- Time-limited gathering location.
- Location exposes injector to violence, robbery, sexual assault, arrest.

Social:

- Unfamiliar, unknown shooting partner(s).
- Hurried; dopesick.
- Unfamiliar, unknown drug source.
- Quality, strength of drug unknown.

A safe setting would be the opposite of the above.

** Definition:

An individual who is “dopesick” is experiencing advanced stages of drug withdrawal symptoms and, typically, is focused with singular intensity on obtaining his/her next drug dose.

▪ **IDU Injection Drug User:**

Individuals who inject drugs

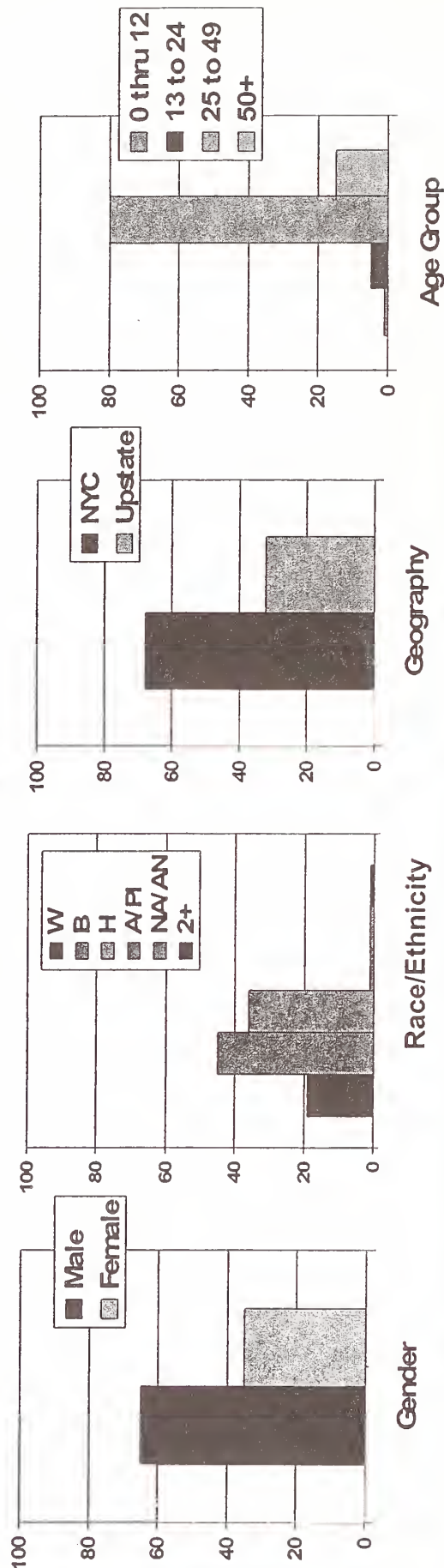
- May or may not also use alcohol; may or may not use other drugs by non-injection-related routes
- Drugs may or may not be illicit
- May or may not be sexually active; may be involved in the sex industry and/or exchange sex for drugs

Sub-group: Men who inject drugs and also have sex with men

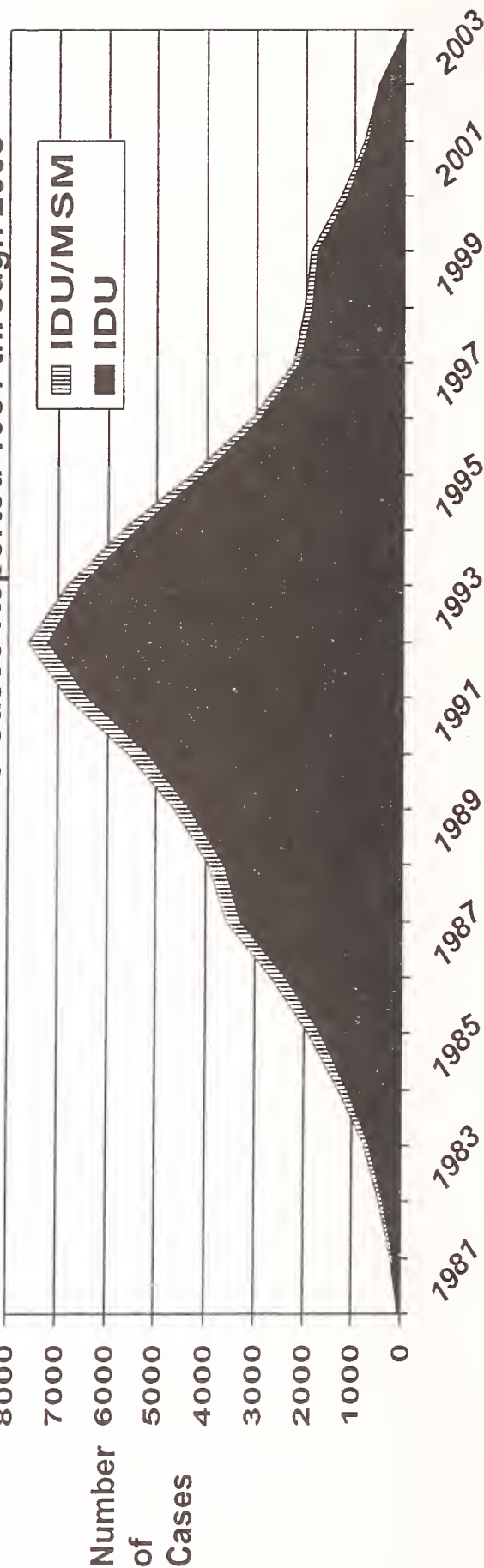
IDU and MSM/IDU

New York State Data through December 31, 2003

HIV (not AIDS) Cases Reported from June 1, 2000 - December 31, 2003 – by Percent



IDU + MSM/IDU – Annual AIDS Cases Reported 1981 through 2003



Resources

- [1] Strathdee SA et al. "Sex differences in risk factors for HIV seroconversion among injection drug users," *Archives of Internal Medicine*, (2001)161:1281-1288. As reported in Mathias R, "High-Risk Sex is Main Factor in HIV Infection for Men and Women Who Inject Drugs," *NIDA Notes*, NIDA, National Institute of Health. Vol. 17, No. 2 – Research Notes. http://www.drugabuse.gov/NIDA_Notes/NNVol17N2/HighRisk.html.
- [2] *NIDA Notes*, "Principles of HIV Prevention in Drug-Using Populations," NIDA, National Institute of Health. http://drugabuse.gov/POHP/FAQ_1.html
- [3] Getting Off Right, Harm Reduction Coalition.
www.harmreduction.org/idu/idu_manual.pdf
- [4] Koester S, Glanz J, and Baron A, "Drug Sharing Among Heroin Networks: Implications for HIV and Hepatitis B and C Prevention," *AIDS and Behavior*, Vol. 9, No. 1, March 2005.

Heterosexuals

World AIDS Day, December 1, 2004, focused on the vulnerability of women to HIV/AIDS. Globally, women already account for nearly half of all adults living with HIV. Further, in some African countries, HIV is five times as high in young women than among their male counterparts. In the US, women of color have been disproportionately infected: 83% of women diagnosed with AIDS are black and Hispanic even though this group constitutes only 25% of US women. [1]

Heterosexual males are also being reported with AIDS in greater proportion of total cases over time as shown below. The column "Newly Diagnosed with AIDS" represents newer cases than those represented by "Living with AIDS."

	Heterosexual Males Living with AIDS	Heterosexual Males Newly Diagnosed with AIDS
NYC	6.9%	9.2%
NYS (excluding NYC)	8.2%	12.4%

New York State HIV/AIDS Surveillance Semiannual Report – Cases Diagnosed through June 30, 2004

The primary HIV risk for non-drug injecting heterosexual females and males is oral, vaginal and anal sexual contact. However, as with all other behaviors, successful HIV prevention is dependent on understanding the intertwining personal, interpersonal, and community norms that affect decision-making and risk-taking.

Recent research has investigated these themes as they affect both individual- and couple-level behaviors.

- Among 217 urban, minority women and their main, male sexual partners the frequency during the most recent 90 days of 6 risk factors were measured and combined with individual demographics/KABB* to create a couple-specific risk index score. Lower levels of relationship satisfaction and higher levels of intimate violence contributed to higher HIV/AIDS risk scores.
 - ~ Understanding the role of interpersonal factors on couple risk and development of relationship-based prevention activities is crucial. [3]

* KABB: Knowledge, Attitudes, Beliefs and Behaviors

- Semple and colleagues noted significant differences in the sexual practices of non-injecting, heterosexual, HIV+ women and men who reported having at least one unprotected incident of oral, vaginal, or anal sex with an HIV- negative person or a person of unknown serostatus during the most recent four months:

Sexual Risk Practices of HIV+ Heterosexual Men and Women [4]

Behavior	Men	Women
Vaginal sex		
Didn't have vaginal sex	5.0%	0%
Always used condom	50.0%	44.4%
Sometimes used condom	20.0%	40.8%
Never used condom	25.0%	14.8%
Oral sex		
Didn't have oral sex	15.0%	7.4%
Always used condom/ dental dam	0%	0%
Sometimes used condom/ dental dam	15.0%	25.9%
Never used condom/ dental dam	70.0%	66.7%
Anal sex		
Didn't have anal sex	80.0%	81.5%
Always used condom	15.0%	3.7%
Sometimes used condom	5.0%	7.4%
Never used condom	0.0%	7.4%

- Often, in the discussion of heterosexual HIV risk, the assumption is made that HIV transmission prevention is the primary concern and overrides fertility concerns, desire for parenthood, and the cultural pressure for reproduction. Panozzo and colleagues explored these latter concerns among heterosexual, HIV+ persons in partnership with a serodiscordant (HIV-negative) person. In this group, 25% of couples already had one or more children.

20% of HIV-positive women aged 20-40 and 22% of HIV-positive men aged 20-50 reported a desire to have children during the study period. If those who currently deferred this desire are also considered, the proportion is 48% of HIV-positive women and 38% of HIV-positive men. These figures are very similar to those in HIV-negative individuals. [5]

NIR/NRR

- No Identified Risk/ No Risk Reported (NIR/NRR) has been a troublesome category in the CDC's Hierarchy of HIV/AIDS Risk Categories for more than 10 years. Originally intended to capture those relatively few HIV and AIDS cases for which, upon confirmation and processing, there was limited or no behavioral risk information, the category has grown to as much as 35% of AIDS cases at some points in time. An even larger proportion of HIV cases are, at least initially, listed as NRR – often due to the minimal data included in electronic laboratory reporting – in those jurisdictions where HIV-named reporting is in place.
- Currently, for a case to be assigned to the heterosexual transmission category, the individual (or the individual's medical record) must indicate only heterosexual contact *and* must document the transmission risk category of the positive heterosexual partner by whom the individual was infected. If the partner's risk is not documented, the case is placed in the NIR/NRR category. This contrasts with the definition of MSM wherein the individual male simply reports sexual contact with a man; no other collaborating information is required for placement in the MSM category.
- Amy Lansky and others at the Division of HIV/AIDS Prevention, CDC, have described one methodology for use, at the national level, in redistribution NIR/NRR cases. Using data from the SHAS (The Supplement to HIV/AIDS Surveillance), the authors developed a statistical model for classification of women by transmission category. Using variables in the model such as alcohol abuse, non-injection drug use, crack use, diagnosis year, age, employment and geographic region, 81% of women previously classified as NNR were reclassified as heterosexual. Another 16% were reclassified to IDU for a total of 97.5% being reclassified. [2]
- For a second method, New York City DOHMH and New York State epidemiologists worked together to create a local sub-category, 'presumed heterosexual,' to attempt to bring some individuals reporting only heterosexual risk but unable to meet the strict definition of the CDC's hierarchical 'Heterosexual Risk' category, into a more relevant grouping. Approximately 30% of NIR cases are typically reclassified, in NYC, as 'presumed heterosexual.'

Resources

- [1] World AIDS Day --- December 1, 2004. (2004 *MMWR*, Center for Disease Control and Prevention, 53(46);1083.
- [2] Lansky A, Fleming P, et al., A Method for Classification if HIV Exposure Category for Women Without HIV Risk Information," (20010 *MMWR*, Center for Disease Control and Prevention, 50(RR06);31-40.
- [3] Witte SS, El-Bassel N, et al. Interpersonal factors predicting HIV/STD risk among heterosexual couples. Abstract #27562, 129th Annual Meeting of the American Public Health Association, Atlanta, GA, October, 2001.
- [4] Semple SJ, Patterson TL, and Grant I, Gender Differences in the Sexual Risk Practices of HIV+ Heterosexual Men and Women, (2002) *AIDS and Behavior*, 6(1).
- [5] Panozzo L, Battegay M, et al. High risk behavior and fertility desires among heterosexual HIV-positive patients with a serodiscordant partner – two challenging issues, (2003) *Swiss Medical Weekly*. 133(7-8):124-7.

Mother-to-Child-Transmission

New York State has been known as the epicenter of the perinatal HIV epidemic since the recognition of the disease. New York is now the epicenter of *prevention* of Mother-to-Child-Transmission. By means of a number of interwoven regulatory requirements, a commitment to high standards of prenatal care, education and access, careful program monitoring and mother/child post-natal follow-up the number of HIV-infected infants has decreased more than six-fold between 1997 and 2004.

Mother-to-Child-Transmission (MTCT) is the transfer of HIV infection from the mother to her infant occurring during the time period surrounding birth and breastfeeding. This includes those infants infected during pregnancy, delivery and/or birth or infected through breastfeeding.

NB: MTCT was previously referred to as perinatal transmission. This transmission category, as used by the Centers for Disease Control and Prevention, *excludes* transfusion and hemophilia-related HIV infections

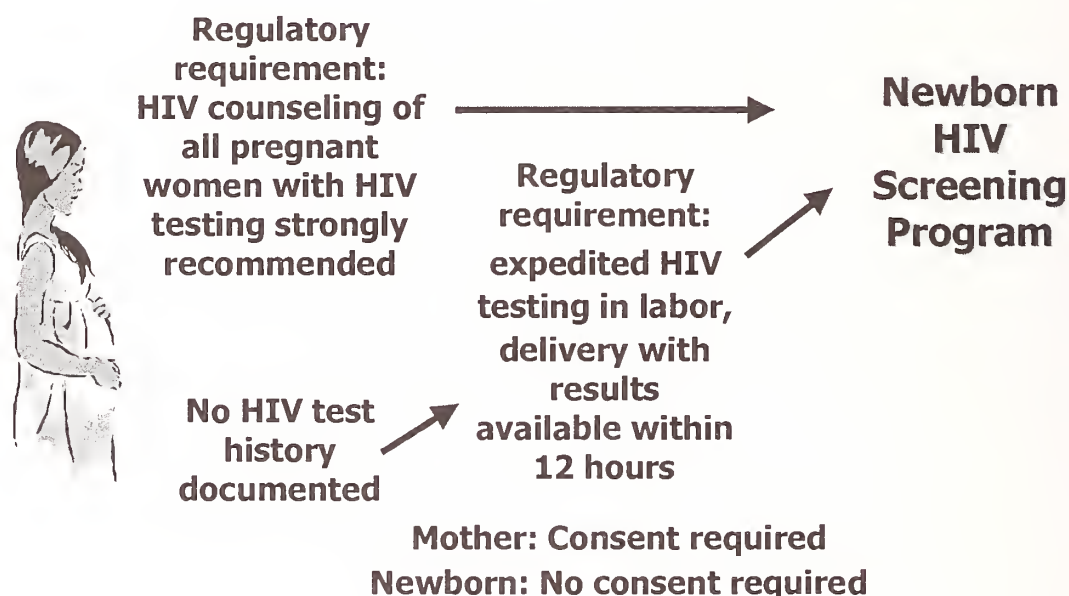
The Maternal-Pediatric Prevention and Care Program is a comprehensive approach that seeks to address many of the steps in the chain of events leading to an HIV-infected child. The goal of the Maternal-Pediatric Prevention and Care Program in New York State is to reduce MTCT HIV transmission to the lowest possible level and to ensure that HIV-positive mothers and their infants have access to the care that they need. This includes:

- Ensuring access to prenatal care for all pregnant women
- Establishing HIV counseling and recommended testing as a standard of prenatal care
- Ensuring that all HIV-positive pregnant women are offered antiretroviral therapy for their own health and to reduce the risk of MTCT HIV transmission to their infants
- Ensuring that HIV test information is transferred in a timely way from the prenatal care site to the anticipated birth facility
- Conducting expedited testing in the delivery setting for all women/newborns for whom prenatal HIV test results are not available
- Conducting HIV testing on all blood samples submitted to the Department of Health's Newborn Screening Program (NSP). (Testing through the NSP

serves as a quality check and provides crucial surveillance information which is then used to target and evaluate NYS interventions to reduce MTCT HIV.)

The following schematic displays the relationship of various program components to one another and to the Newborn HIV Screening Program:

HIV Counseling and Testing of Pregnant Women and Newborns in New York State

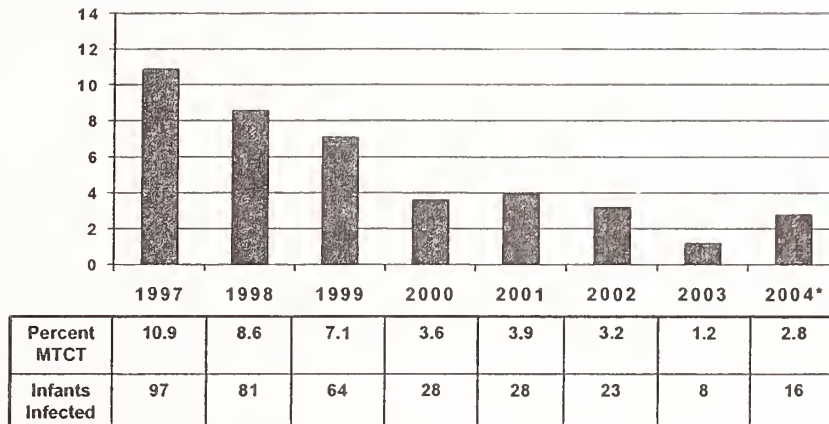


As a result of testing and treatment to prevent HIV transmission in New York State, rates of MTCT transmission have steadily declined from 10.9% in 1997 to 2.8% in 2004. (Year 2004 data is preliminary and, therefore, may change over time.)

Percent of Deliveries by HIV Positive Mothers that Resulted in HIV Transmission to the Baby-- New York State 1997- 2004* by Year of Delivery

(*2004 Data is Preliminary)

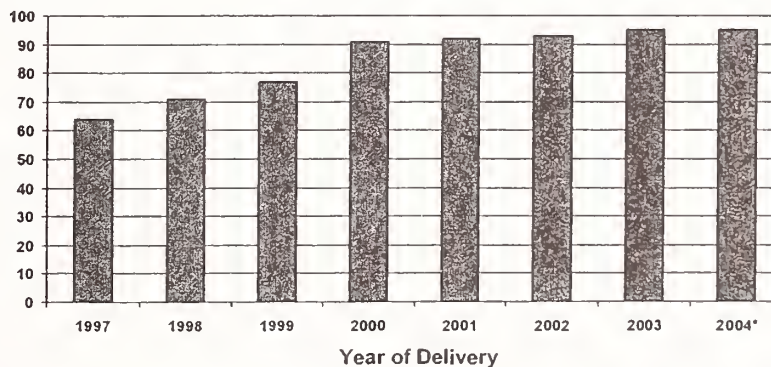
Percent Mother-to-Child Transmission (MTCT)



From 1997 to 2004, the percentage of women aware of their HIV status before delivery increased from 64% to 95%.

NYS Women Aware of Personal HIV Status Before Delivery New York State Perinatal HIV Surveillance Program

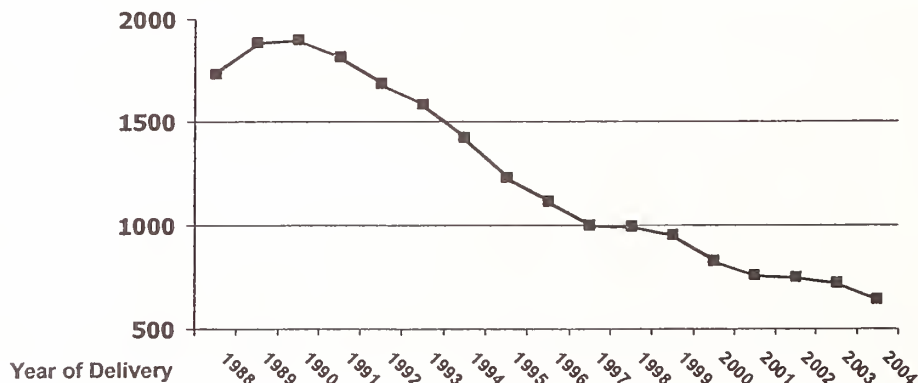
Percentage



NYS Survey of Childbearing Women HIV Prevalence by Year of Delivery: 1988 – 2004*

(*2004 data is Preliminary)

Number of HIV-positive Deliveries

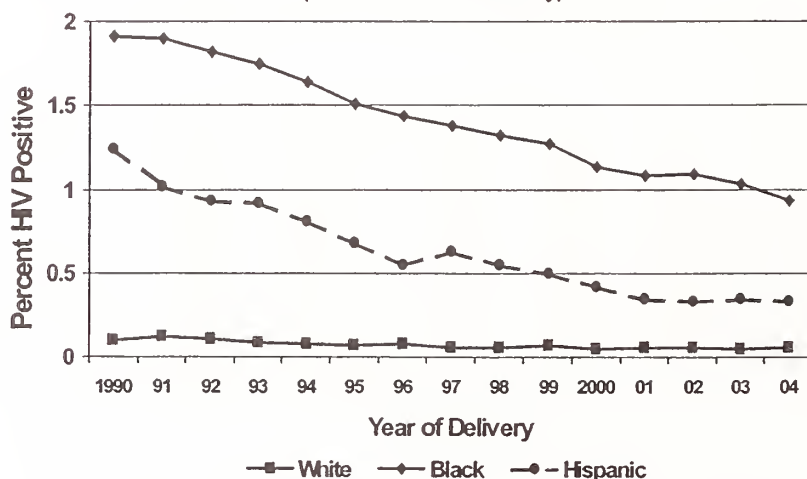


Since 1990, there has been a 66% decline in the number of HIV-infected women giving birth in NYS: 1,898 in 1990 to 642 in 2004

HIV prevalence among childbearing women is determined by testing of infant heel-stick specimens by the Wadsworth Laboratory, a center within the NYSDOH. In 2004, of the 239,167 women whose infants were tested, 642 women, or 0.27%, were identified as HIV-infected based on the outcome of the newborn's test.

HIV Prevalence in Women Giving Birth in New York State by Race/Ethnicity 1990-2004*

(*2004 Data is Preliminary)



* Asian/PI and NA/AN are not included due to confidentiality constraints

The prevalence of HIV varied by a number of descriptors including geographic location, mother's age at time of birth, and race/ethnicity.

In recent years, AIDS Institute staff has examined the medical records of women who have given birth to HIV-infected infants. Characteristics commonly found in women who give birth to HIV-infected infants are:

- No prenatal care
- Difficulty with medication adherence
- Acute infection during pregnancy (as determined by a negative HIV antibody test earlier in pregnancy followed later by a positive test for HIV)

These same women also experienced life situations/stressors including:

- Using drugs and/or alcohol
- Being an immigrant
- Experiencing homelessness
- Experiencing mental health problems
- Being a resident of New York City

Summary Comments

New York State has achieved a dramatic reduction in Mother-to-Child-Transmission of HIV infection. Having begun with identification of key HIV infection intervention points and continuing to the end process of program evaluation, each step that previously led to an infected child now leads to increased access to prevention, care, medication, prenatal services and follow-up of mother/child pairs.

References:

- [1] New York State Comprehensive Newborn Screening Program, Annual Summary Report, 2001 Edition, New York State Department of Health, Albany, NY. 2003.
- [2] Glaros, Roberta, "Study of 43 Cases of Residual Mother-to-Child HIV Transmissions in New York State," 2005 National HIV Prevention Conference, Atlanta, Georgia.

Persons at Particular Risk



This section of Question #3 examines the various subpopulations who, because of their particular condition, situation, or activity, may be at risk of or infected by HIV

Populations at Particular Risk

Introduction

The following sections enumerate the ways in which various individuals within communities at particular risk may be hampered in their attempt to practice sound HIV prevention activities and techniques. However, individuals do not exist in a vacuum but rather interact in relationship to families, partners, friends, coworkers, caregivers, community groups, businesses, organizations, governments, and institutions, etc. Each interaction of a couple, alone, or as a part of a family group, for example, multiplies the skills and the deficits of each individual by that of the other. It is at this point, as with the individual, that the community can provide an open supportive environment in which community members can prevent HIV transmission -- or hinder HIV prevention activities by inaction or repressive actions.

Successful practice of sexual and drug-related HIV prevention activities requires access to male and female condoms and new, sterile injection syringes. Good prevention practice also includes access to:

- No- or low-cost anonymous and confidential HIV counseling and testing including access* to blood, urine, or oral fluids testing, rapid testing, appropriate confirmatory testing and quality-monitored laboratory, record-keeping and counseling services
 - * In this discussion 'access' embodies all levels of resources and actions necessary to partake of a service or to obtain information, supplies, and/or care.
- No- or low-cost health care as a follow-up to counseling and testing
- Individual, couple, and/or group educational workshops offering basic prevention education, including correct use and application of sexual and drug use-related HIV prevention supplies, in individual, small group, and larger group settings of varied numbers of sessions
- High quality, science-based, uncensored HIV/AIDS information and resources for prevention and care
- No- or low-cost HIV prevention supplies including but not limited to:
 - Clean, disposable cookers, spoons, filters (cottons)
 - Undiluted household bleach and clean water
 - Tourniquets, lighters, matches
 - Alcohol pads, tissues, and band-aids
 - Rubber pipe stem gaskets, ascorbic acid tablets, and screens
 - Male and female condoms
 - Gloves, dental dams, and finger cots

- Lubricants appropriate for use with latex products and formulated to decrease membrane sensitivity and allergic reactions with frequent use
 - Spermicidal creams, jellies, gels, films, and suppositories appropriate for use with latex products and formulated to decrease sensitivity and allergic reactions with frequent use. These products should *not* contain Nonoxonyl-9, which has been shown to cause skin irritation.
 - Cervical caps, diaphragms, and other barrier contraceptives that decrease transmission of HIV and sexually transmitted diseases/infections
 - Soap and waterless hand sanitizer
 - Syringes, ideally, but not exclusively, with fixed needles, in a variety of sizes and gauges.
-
- Screening and treatment for sexually transmitted diseases/infections, hepatitis, and tuberculosis

Inmates and HIV/AIDS in NYS

Background

Although the number of HIV-infected inmates has steadily declined nationwide since 1999, New York State remains first in the US in number of HIV-infected inmates and in percent of the custody population* that is HIV-positive. At year end, 2003, 7.6% of the NYS custody population, 5,000 individuals, were estimated to be HIV positive. The NYS figures account for 20% of the HIV-positive individuals in custody populations in the US. By contrast, Florida, with the second highest number of HIV-infected inmates in the US, reported that 3.9% of the custody population (3,112 individuals) is HIV-positive.

Among the males in the NYS custody population, 4,570 (7.3%) are estimated to be HIV-positive; among females an estimated 430 are HIV-positive for a seroprevalence among women of 14.6%. Over 10% of all female inmates known to be HIV-positive in the US are located in two states, New York and Maryland where 11.1% of female inmates are HIV-positive. New York is the only state where more than 5% of male inmates are known to be HIV-infected.

New York State also has the largest population in the US of inmates with AIDS: 800 individuals or 1.2% of the custody population at year end 2003. Texas and Florida follow closely with 778 and 711 inmates with AIDS, respectively. The NYS inmates with AIDS account for over 13% of the nationwide inmate AIDS population.

Using a combination of data reported through the Death in Custody Reporting Act of 2000 and the National Prisoner Statistics – Series 1, NYS experienced 27 deaths due to HIV/AIDS during 2003 among the custody population for an AIDS-related death rate of 41 deaths per 100,000 inmates. Numerous other states experienced greater HIV/AIDS-related death rates.

- * The custody population of a given state is composed of inmates in both State- and Federal-run penal institutions located in that state. [1]

New York State Activities

From 1988 to 2003, the New York State Department of Health in collaboration with the NYS Department of Correctional Services (DOCS) has studied HIV seroprevalence in inmates entering the state correctional system through a series of seven cross-sectional, prospective surveys. Blood left over from medical screening during routine DOCS intake is linked with medical data including Hepatitis B (HBV) Surface Antigen and syphilis

testing before all identifiers are removed from the specimen and study file. The leftover blood is then tested anonymously for HIV antibody.

A major limitation is that data collected on incoming inmates is not representative of the total inmate population under custody. However, the study has shown a decline in HIV seroprevalence among incoming inmates over time for both males and females. Male HIV seroprevalence rates dropped from 17.6% to 4.5% between 1988 and 2003 while the rate for women declined from 18.8% to 11.4% during the same time period.

Unlike other racial/ethnic groups, black women inmates did not experience a decrease in seroprevalence during the study period. Hispanic inmates, men and women alike, experienced the greatest decline in rates over the period of observation. White males and females experienced the lowest rates of any group over time; white males experienced a greater decline in rate than did white females.

Among both male and female inmates entering NYSDOCS facilities, self-reported injection drug use fell over time: from 27.7% in 1988 to 7.3% in 2003 among men and from 28.8% in 1988 to 16.4% in 2003 among women. The 2003 rate for males was only slightly increased from the lowest rate of self-reported injection drug use (5.9% in 2000). The lowest rate seen in women was 12.1% in 1996.

Syphilis has also decreased among both men and women inmates entering the NYSDOCS system. In females, it decreased from a high of 27.9% in 1992 to 8.3% in 2003. Syphilis prevalence in males dropped but not as dramatically; 1992 saw a high of 6.8% as compared to the 2003 level of 3.2%.

Hepatitis B virus surface antigen, a marker of possible chronic hepatitis B, was found to be positive in 1.1% of male inmates and 0.8% of females in 2003. Hepatitis C antibody testing was included for the 2000 and 2003 study groups. In 2003, 24.1% of females and 13.3% of males had hepatitis C antibody; rates in 2000 were similar.

References

- [1] Bureau of Justice Statistics Bulletin, *HIV in Prisons, 2003*, US Department of Justice, September 2005, Washington D.C.
<http://www.ojp.usdoj.gov/bjs/juststats.htm>

- [2] Bureau of HIV/AIDS Epidemiology, *HIV Seroprevalance and Seroincidence Among Inmates Entering the New York State Correctional System: 1988-2003*. NYS Department of Health in Collaboration with the NYS Department of Correctional Services, 2005, Albany, New York.

NYS Probation and Correctional Alternatives

- New cases opened decreased 2% from 85,492 cases in 2000 to 83,526 cases in 2001
- 69,910 regular investigations (pre-sentence, pre-plea, etc.) and 80,744 other investigations were conducted in 2001 for a total of 150,654 investigations conducted, a 3% increase over 2000
- The number of criminal cases supervised during 2001 increased over those of 2000 both statewide and in NYC:
 - NYC cases under supervision: 93,584
 - NYS excluding NYC under supervision: 108,290
 - Statewide under supervision: 201,874 (3% increase over 2000)

NYS Division of Parole

Fiscal Year 2001-2002				
Type of Interview				
Disposition	Initial	Reappearance	Violater	Total
			Re-release	
Released	7,415	1,917	5,158	14,490
	46%	27%	85%	49%
Postponed	981	654	531	2,166
	6%	9%	9%	7%
Denied	7,746	4,662	346	12,754
	48%	64%	6%	44%
Total	16,142	7,233	6,035	29,410

Additional NYS Criminal Justice Agencies of Interest

New York State Division of Parole

The New York State Division of Parole prepares inmates for release and provides community-level supervision of parolees until the completion of their sentences.

New York State Probation and Correctional Alternatives

The Division of Probation and Correctional Alternatives (DPCA) funds and oversees a variety of pretrial services and correctional alternative programs throughout New York State, often referred to as Alternative to Incarceration or ATI programs. These programs may fall under the authority of governmental or non-profit agencies. They operate in conjunction with the criminal justice system in all New York State counties and the City of New York.

Currently, DPCA funds programs designed to reduce reliance on pretrial detention or incarceration. The following are examples of alternatives to detention and incarceration (ATI) measures and programs in New York State:

- Mental Illness Programs
- Pretrial Services
- Treatment Alternatives to Street Crime (TASC) and Drug and Alcohol Programs
- Specialized Programs
- Community Service Programs
- Defender Based Advocacy

References

- [1] Bureau of Justice Statistics Bulletin, *HIV in Prisons, 2003*, US Department of Justice, September 2005, Washington D.C.
<http://www.ojp.usdoj.gov/bjs/juststats.htm>

- [2] Bureau of HIV/AIDS Epidemiology, *HIV Seroprevalance and Seroincidence Among Inmates Entering the New York State Correctional System: 1988-2003*. NYS Department of Health in Collaboration with the NYS Department of Correctional Services, 2005, Albany, New York.

Individuals with One or More Disabilities

A number of sources including the US Census, the Kaiser Family Foundation and the National Organization on Disability report that between 18-20% of persons in the US, or approximately 1 person out of 5, have one or more disabilities.

Most disability data is given only for persons ages 16 (or 20) to 64, civilian, and non-institutionalized. This omits children and young people, seniors, persons in the military, and all institutionalized individuals including but not limited to the incarcerated, mentally ill, and the severely disabled. Classification and definition of disability also varies within and among surveys and studies making it difficult to compare data over time or by population.

Notwithstanding these definitional issues, the disability of an individual can vary by:

- *Onset*: Just over half of persons with disabilities say that their disability began at birth through young adulthood (24% of those ages 0 to 19; 27% of those 20 to 39) and the remaining half report onset in middle age or after age 55 (28% ages 40-55; 21% over age 55)
- *Limitation of activities*: 36% of individuals with disabilities describe themselves as unable to work, go to school, or to keep up their homes. Thirty-seven percent stated that they are able to work but are limited in amount or type of work or labor that can be accomplished
- *Severity*: The proportion of individuals with disabilities who rate their disability as 'severe' or 'somewhat severe' has remained stable over time at ~61% (59% in 1994; 63% in 1998; 60% in 2000)
- *Type*: Disabilities are typically classed as sensory (i.e. sight, hearing), physical (i.e. spinal disease, condition or injury), and/or mental (i.e. developmental, retardation, injury to the brain)

Disability-specific Risk

Potential barriers to successful practice of sexual and drug-related HIV prevention activities at the individual level:

- Individuals with disabilities may not have the physical ability to practice sexual or drug-related HIV prevention activities without assistance from a caregiver, family member, personal care attendant**, partner, or other trusted individual

- Family members, friends, health care providers, and others in contact with an individual with disabilities may assume that, due to the disability, the individual does not desire to be nor is active sexually or using drugs
- Individuals with disabilities may not have the necessary mobility to obtain supplies for safer sexual or drug-related HIV prevention activities
- Individuals with disabilities may not trust or be able to confide in health care workers or staff at independent living centers in order to obtain sexual or drug-related HIV prevention education, supplies, or to learn prevention activities
- Individuals with hearing loss and/or sight-related disabilities may experience problems accessing* information and care:
 - Very little, if any, HIV prevention material has been developed to address *disability-specific* sexual and drug-related HIV prevention activities nor has the disability community been directly targeted in a disability-specific manner
 - Those who have been deaf since birth and are ASL (American Sign Language) practitioners may not understand or apply information translated for them from standard English, i.e. 'signed' English, as ASL, an entirely separate language, has a very different syntax and grammar
 - Those who have acquired hearing loss and those deaf since birth may not have access to a known and trusted translator and, depending on hired or provided translators, may find that translator unwilling, unable, or not trusted sufficiently to discuss HIV, sexuality, and sexual and drug-related HIV prevention activities
 - Very little HIV/AIDS information is available in Braille
 - Individuals with sensory disabilities may be of low literacy level in any or all manners of communication
- Individuals with disabilities, while having many friends and acquaintances in the disability community, may be unwilling to share their sexual and drug-related practices due to fear of lack of acceptance and stigmatization, even though hiding denies them one more potential avenue of support
- Individuals with disabilities may not have the necessary privacy to prepare for and engage in sexual or drug-related HIV prevention activities
- Individuals with disabilities who employ a personal care attendant may not be able to share sexual or drug-related needs with that attendant and therefore cannot prepare for and engage in HIV prevention activities

- Individuals with disabilities may have personal care attendants who are not trained, are unable -- or unwilling -- to assist the individual to prepare for and engage in sexual or drug-related HIV prevention activities
- Individuals with disabilities with mental and/or developmental limitations may not be able to learn, negotiate, use, and/or maintain sexual or drug-related HIV prevention activities
- Individuals with disabilities may not have sufficient mobility or other means to meet potential sexual or drug use partners and therefore may resort to less safe methods of finding partners and meeting places
- Individuals with disabilities may be involved in partnerships of unequal status, i.e. where a partner controls their access to sexual or drug-related HIV prevention activities, declines to participate in prevention, or who otherwise denigrates, mistreats and/or abuses them

Persons with disabilities may also differ by the nature and severity of their disability, by the length of time they have experienced the disability, and by their personal response to their condition. As with all individuals, persons with disabilities may be limited beyond their disability by literacy and/or educational level; income; housing concerns; geographic location; gender; religion; citizenship status; age; personal use of alcohol and/or other intoxicants; family and relationship status; general health or any of the myriad of barriers experienced by everyone struggling to stop the spread of HIV.

Individuals with one or more disabilities and who are HIV-antibody negative:

- The individual with disabilities may be limited in both HIV/AIDS prevention education and negotiation skills due to lack of disability-specific media and educational activities. Without this information and skill set the individual may not be able to adequately clarify his/her "safety" limits and commitment to HIV prevention to potential drug and/or sexual partners and, therefore, leave themselves vulnerable to unsafe activities
- The individual with disabilities may have limited access to HIV counseling and testing and/or no access to counseling and testing that is inclusive of all individuals regardless of type and severity of disability
- The individual with disabilities may not be able to access HIV prevention supplies and education on proper use. Lack of access to new, clean, sterile equipment may lead to sharing of or reuse of supplies

- The individual with disabilities needs access to HIV sexual and drug-related prevention trained personal care attendants, health and mental health care workers. Caregivers and family members may also need education and training. Absent this support, the individual may be resorting to meeting places, partners, and activities that bear increased risk of HIV transmission

Individuals with one or more disabilities and who are HIV-antibody positive:

- The individual with disabilities and with disclosure skills may be able to either disclose their HIV status to potential drug and/or sexual partners or to clarify his/her "safety" limits and commitment to HIV prevention in those settings where status disclosure is inadvisable or unsafe. This action may prevent the transmission of HIV to others as well as exposure to new strains of HIV (superinfection)
- Access to partner notification and/or support for self-notification regardless of type and severity of disability on the part of the index individual or their partner(s) may assist in stopping transmission from those who may not know their HIV-antibody status and to those who assume their partner to be negative for HIV
- The individual with disabilities is more likely to use, understand the workings of, and pass along information and guidance on use of sexual and drug-related HIV prevention supplies and education materials when tailored to the specific needs of persons with disabilities. Proper and consistent usage would be supported if delivery of such articles and supplies were to be carried out by persons with understanding of and familiarity with the wide range of disabilities
- Persons with disabilities need HIV sexual and drug-related prevention training for personal care attendants, health and mental health care workers, caregivers, and family members. This support allows the individual with a disability to be integrated into the community and to stabilize their lives in ways supportive of good health and safe HIV prevention and care activities

HIV sexual and drug-related prevention activities needed in the Disability Community:

- Education and skills training at all service and care levels to assist the Disability Community to increase awareness of and openness to the HIV sexual and drug-related prevention needs of their community members
- Educational and skills building for the HIV/AIDS Community conducted by members of the Disability Community

- Increased disability-specific HIV education, prevention and care messages developed within the Disability Community using indigenous modes of outreach, communication and education
- Increased access to HIV sexual and drug-related supplies and equipment including but not limited to: delivery for those with mobility limitations, increased accessibility for other persons with disabilities, and distribution staff who familiar with and understand the wide range of disabilities
- Increased cross-training of the HIV/AIDS and Disability Communities
- HIV sexual and drug-related prevention training for personal care attendants, health and mental health care workers, and caregivers

References:

New York State and National Data, Behavioral Risk Factor Surveillance Survey, Centers for Disease Control and Prevention, <http://www.cdc.gov/brfss/pubbrfdat.htm>

Disability in New York State, NYSDOH, <http://www.health.state.ny.us/nysdoh/prevent/prevalence.htm>

The Nature and Severity of Disability in America, The National Organization on Disability, <http://www.nod.org>

American Community Survey, US Census Bureau, <http://www.census.gov/acs/www/>

* *Access*, in the context of disability, refers to all barriers to care or service including those pertaining to the disability of the individual but also to the barriers specific to the service, i.e. distance, hours, language spoken, cost, confidentiality, etc.

** In this discussion, a personal care attendant is a trained, salaried professional. A caregiver may be a partner, friend, family member, community organization volunteer or a team of such persons or may be a salaried individual with or without health care skills.

Classification of Disability Type for Persons 16 to 64 Years of Age

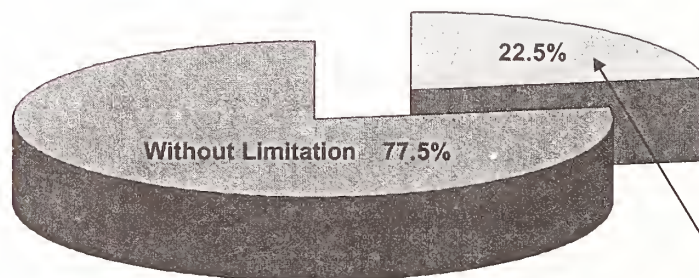
US Census Bureau

- Sensory disability
- Physical disability
- Mental disability
- Self-care disability
- Go-outside-home disability
- Employment disability

The first three categories classify the type of disability; the last three classify limitations resulting from the specific disability. In the US Census reports there is a great deal of overlap of all categories

Behavioral Risk Factor Surveillance Survey (BRFSS)

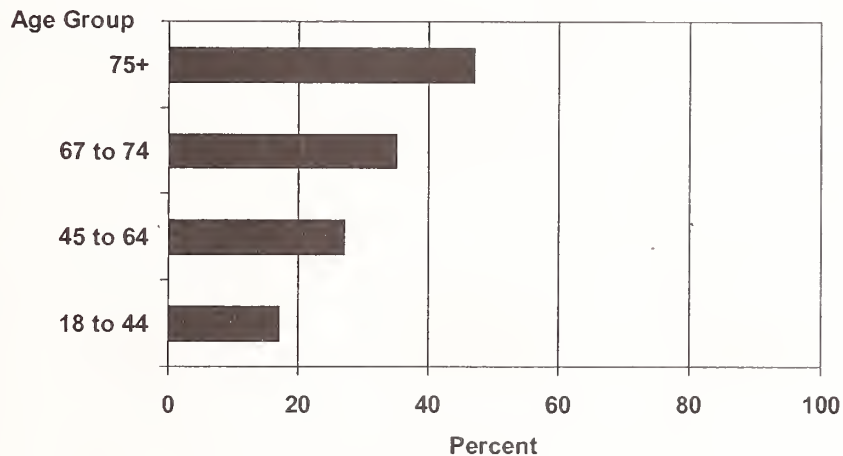
Centers for Disease Control and Prevention - 2000



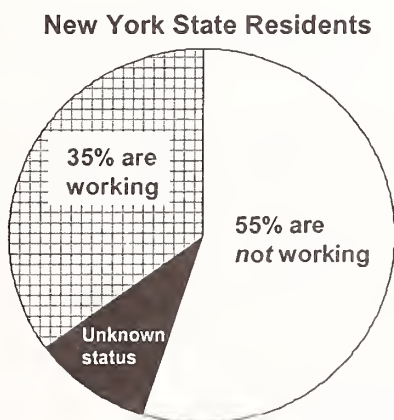
According to the Year 2000 BRFSS, among the non-institutionalized population in NYS, 22.5% or approximately 1 in 5 people have some activity limitation

Prevalence of Activity Limitation Among NYS Adults by Age Group – 2000

Behavioral Risk factor Surveillance Survey, CDC 2000; NYSDOH



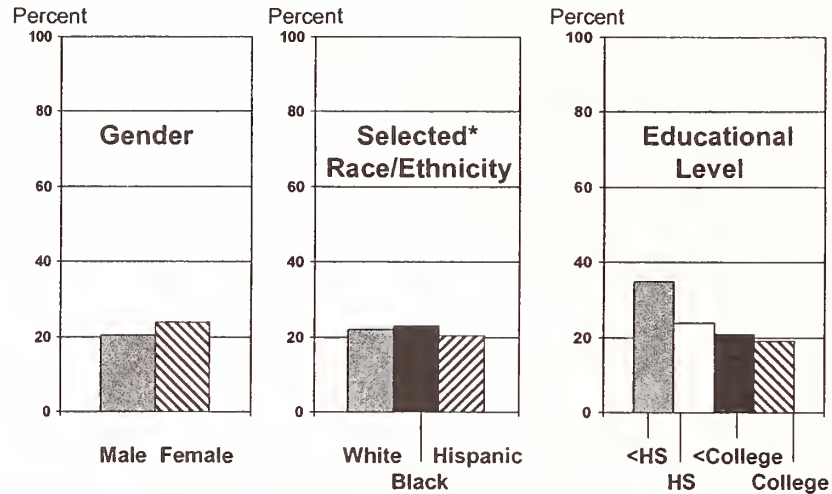
Nearly 900,000 NYS residents have a work- related disability according to the 1990 Census*



- Among the nearly 12 million non-institutionalized persons ages 16 to 64 in NYS, approximately 7.5% have a work-related disability
- 2.5% report having a mobility limitation, 4.5% report a self-care limitation, and 5.7% report having either a mobility or self-care limitation
- While there exists some overlap in these categories and some persons have more than one disability, Kaiser Family Foundation reports that approximately 18% of people in NYS have a disability

*The most recent year for which this data is available

Prevalence of Activity Limitation Among NYS Adults by Gender, Selected Race/Ethnicity, and Educational Level Behavioral Risk Factor Surveillance Survey, CDC - 2000



* Only these categories were available at the state level; NYSDOH prefers to use inclusive race /ethnicity data at all levels

Mentally Ill Chemical Abusers (MICA)

Use/abuse of drugs and alcohol represents a major obstacle to the successful rehabilitation of psychiatrically-disabled persons. Prevalence estimates for current chemical abuse among individuals in psychiatric treatment range from 24% to 49%. [1]

Laudet et al in the *American Journal of Orthopsychiatry*, report on the perceived reasons for substance use among persons with a psychiatric disorder. Among 310 dually-diagnosed persons, primarily male and of ethnic minority membership, in a NYC study group:

- Use of alcohol and drugs began in adolescence; subsequent use was extensive
- 50% reported daily or near daily use of alcohol and marijuana when first beginning their substance use careers; use began often as an attempt fit in, "to be accepted"
- Main substances were crack/cocaine and alcohol
- Main psychiatric diagnoses were schizophrenia, bipolar disorder and depression
- Participants reported drug-free periods of one or more months, typically when in jail, hospital, or other closed environment

Reasons to quit drug and alcohol use included:

- A better life
- Fear of losing custody of children
- Frequent car wrecks
- Threat, direct and indirect, to life

Following a drug-free period, triggers to return to use included:

- No longer in controlled environment
- Loneliness/boredom
- Cravings/temptations
- Stress/increased responsibility

Participants described the relationship of their mental health issues and drug/alcohol use as:

- 2/3 reported that their mental health symptoms worsened if/when they used drugs/alcohol
- 44% responded that "they felt like using 'very much' if/when they experienced symptoms" [2]

References

- [1] Carey KB, Treatment of the mentally ill chemical abuser: description of the Hutchings Day Treatment Program, *Psychiatr Q.* 1989 Winter;60(4):303-16.

- [2] Laudet A, S Magura, H Vogel, and E Knight. "Perceived reasons for substance use among persons with a psychiatric disorder," *American Journal of Orthopsychiatry*, 73(3). 2004.

Individuals who are Homeless

According to the National Coalition for the Homeless, two trends are largely responsible for the increase in homelessness over the past 15-20 years: a growing shortage of affordable housing and a simultaneous increase in poverty.

Eroding employment opportunities have included:

- Less secure jobs with fewer benefits
- Stagnant or falling incomes among low-wage earners
- Declining value and availability of public assistance
- Decreasing support for those who are eligible
- General assistance for single adults reduced or eliminated

Between 1973 and 1993, 2.2 million low-rent units disappeared from the market. Rents have increased faster than personal income so that rent now constitutes a greater proportion of income. The number of low-income renters increased which, in turn, has increased overcrowding, increased occupancy of substandard housing, and increased demand/waiting lists for public housing and housing assistance.

Between 1970 and the mid-1980s an estimated 1 million single room occupancy units were demolished. This particularly displaced poor, mentally ill, and substance-using persons including those with HIV and AIDS. This was particularly harsh in NYC where 87% of \$200.00/month housing was demolished between 1970 and 1982.

Homelessness-specific Risk

Homelessness results from a complex interaction of circumstances that require individuals and families to choose between food, shelter, and other basic needs. This mix is only accentuated by the monetary and lifestyle demands on an individual and family living with HIV/AIDS. [1]

Homelessness can both place an individual, couple or family at risk of HIV/AIDS and can be a symptom or marker of increased risk:

- The individual who is homeless, by definition, does not have a safe place to perform the activities of daily living:
 - Sleep, rest
 - Eat, cook, store food
 - Practice hygiene and good health activities, store hygiene-related and health-related supplies
 - Be sheltered from the weather, environment, other persons

- Be linked to a “place”, an address such that the individual may be eligible for social services, care, and programming
 - A “place” also enhances access to media as a location in which to store TV, radio newspaper, etc.
 - A “place” allows one to properly store medical supplies and medicines, can serve as a locus of homecare, and is a location where medical, social, and mental health clinicians can contact the individual for follow-up, test-of-cure, DOT, etc.
 - Lack of “place” limits the individual’s opportunity to make and maintain ties to supportive family, relationship, and community members. The homeless individual may be difficult to contact or, due to the lifeway of the homeless, be a difficult person with whom to maintain a relationship
 - Conversely, some homeless persons, particularly in squatters’ camps, have formed vital, supportive, and cohesive communities sharing food, shelter, education, and safety

- HIV sexual and drug-related prevention activities require preparation (purchase or gathering of supplies), storage (box of condoms in bathroom cabinet), and easy access at point of use (clothing with pockets, a purse), options rarely open to homeless individuals.

- An individual, forced by lack of housing, to have sex out-of-doors or in atypical locations, is less likely to practice HIV-related prevention or be able to:
 - Choose when, where, or with whom to -- or not to -- have sexual contact
 - Have access to new, clean (sterile, if necessary), dry HIV prevention supplies
 - Insist on use of HIV prevention practices and supplies
 - Negotiate the limits or bounds to type of sexual contact
 - Be sufficiently safe to disclose their HIV-status, if positive
 - Decline to continue if bounds are exceeded or to safely leave the encounter
 - Avoid arrest or other censure

- An individual, forced by lack of housing, to use drugs, particularly but not limited to injectables, out-of-doors or in atypical locations, is less likely to practice HIV-related prevention or be able to:
 - Have access to clean water
 - Have access to a clean, dry surface on which to prepare and/or count out drug dosage
 - Have access to new, clean (sterile, if necessary), dry, HIV prevention supplies and equipment
 - Insist on use of HIV prevention practices and supplies

- Have time to adequately and safely prepare a dose or doses; dispose of or adequately clean all equipment, and clean/cover all injection sites and other drug entry points
- Negotiate the limits and bounds of any type of drug-induced and/or drug-related sexual contact
- Be sufficiently safe to disclose their HIV-status, if positive
- Decline to continue if bounds are exceeded or to safely leave the encounter
- Avoid arrest or other censure

Factors that affect HIV/AIDS risk among HIV-negative homeless persons:

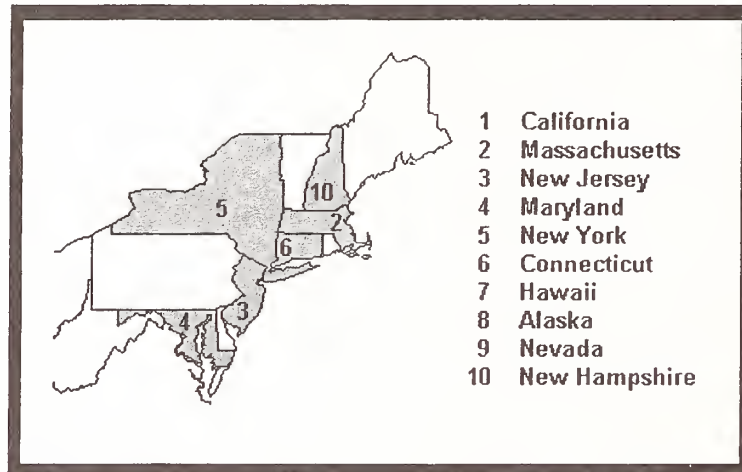
For the HIV-negative but at-risk individual, lack of safe housing pushes the individual into public or semi-public locales for all sexual and drug-related activities. The individual is unable to garner and maintain supplies and therefore may enter each sex and/or drug encounter with insufficient, improperly stored, unclean, or other wise unsuitable supplies. Lacking a safe depository for food and clothing, the individual is more likely to experience negative health events and injuries. These, in turn, may tax the individual's immune system leaving them open to infection and chronic disease.

Factors that affect HIV/AIDS risk among HIV-positive homeless persons:

The HIV-positive individual's lack of shelter makes it difficult if not impossible to properly store and maintain medications, to take those medications on a strict time schedule, and to eat -- or not eat -- at set intervals around medication intake. Being out-of-doors, in a homeless shelter, or a squatters' camp places the HIV-positive individual at increased risk of skin diseases, enteric infections from improperly stored or scavenged food, and, if in a close space, an increased risk of respiratory diseases including TB.

[1] National Coalition for the Homeless, "Causes of Homelessness"
www.nch.ari.net/causes

Housing: Top 10 *Least Affordable* States



National Low Income Housing Coalition

What does it take to *NOT* be homeless?

Number of Hours per Week at Minimum Wage of \$6.00/hr to
Afford to Rent an Apartment

Location		One Bedroom	Two Bedroom	Three Bedroom	Four Bedroom
	Studio				
New York State	98	107	121	150	159
New York State NonMetro	62	64	76	97	110
NYC MSA/PMSA	108	117	131	161	165
Franklin County	54	54	64	83	92

Hourly Wage @ 40 Hours/week Required to Own a Home

Location		One Bedroom	Two Bedroom	Three Bedroom	Four Bedroom
	Studio				
New York State	\$14.74	\$16.00	\$18.18	\$22.48	\$23.78
New York State NonMetro	\$9.24	\$9.55	\$11.47	\$14.51	\$16.57
NYC MSA/PMSA	\$16.27	\$17.60	\$19.58	\$24.08	\$24.77
Franklin County	\$8.08	\$8.10	\$9.67	\$12.42	\$13.75

National Low Income Housing Coalition Data for NYS

Immigrants

The 2002 report of the US Immigration and Customs Enforcement (ICE), Department of Homeland Security, states that:

- A total of 1,063,732 immigrants were admitted to the US during 2002
 - 384,427 (36%) were new arrivals; the remaining 64% were already in the US in 2002 and had their immigration status changed
- 114,827 of these immigrants, or just under 11% of total immigrants, settled in New York State
 - New York City metropolitan area received the 2nd largest number of immigrants: 91,275 in 2002
- Immigrants to the US in 2002 were born on all continents and in all regions:

Africa	60,269
Asia	342,099
Europe	174,209
North America	404,437
Caribbean	96,489
Central America	68,979
Oceania	5,557
South America	74,506
Unknown Place of Birth	2,655

- A total of 126,084 refugees were admitted or experienced a change in immigration status during 2002
- This number also includes 10,252 persons to whom asylum has been granted
- The individuals admitted under this category vary over time as global politics and the perspective of the US government towards those events also varies
- In 1998, for example, 105,000 Hondurans who had entered the US without inspection were granted temporary protected status

Estimates of undocumented immigrants are also a product of the US Immigration and Customs Enforcement (ICE), Department of Homeland Security, and include the following information:

- There were an estimated 7,000,000 undocumented immigrants, or 2.5% of the US population, residing in the US in January of 2000

- Approximately 1/3 of the undocumented arrived legally then overstayed their visa; the remaining 2/3 entered the US by crossing a border without inspection
- Five US states were home to approximately 4.5 million undocumented immigrants in 2000:

California	2,209,000
Texas	1,041,000
New York	489,000
Illinois	432,000
Florida	337,000

- Eight countries of origin each contributed more than 100,000 undocumented immigrants to the US during 2000:

Mexico	4,808,000
El Salvador	189,000
Guatemala	144,000
Colombia	141,000
Honduras	138,000
China	115,000
Ecuador	108,000

References

- [1] US Immigration and Customs Enforcement (ICE), Department of Homeland Security
<http://www.ice.gov/graphics/>

Migrants and Seasonal Workers

The New York State agriculture industry has long depended on the availability of migrant and seasonal workers to assist in all stages of crop production. While mechanization has replaced the need for much of the manual labor of earlier times, certain crops and smaller farms dictate continued human labor input.

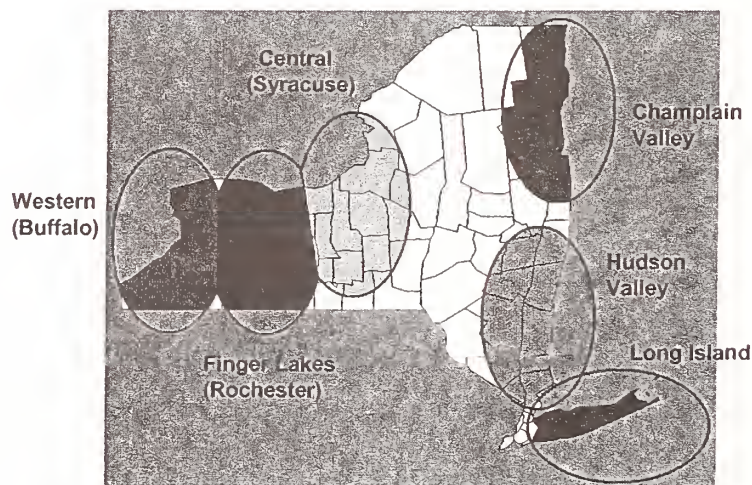
The following two pages are taken from "Coming UP on the Season/Ven a la Cosecha: Migrant Farmworkers in the Northeast" published by Cornell University, the premier academic center for agriculture in NYS. "Facts on Farmworkers in the United States" and "Facts on Farmworkers in New York State" report on findings from the National Agricultural Workers Survey 1997-1998, a project of the US Department of Labor which was published in 2000. The "Facts" also draw on "Health Problems among Migrant Farmworkers' Children in the US" published in the ERIC Digest in 1993.

While migrants and seasonal workers comprise a distinct population, it is one that shares much with other groups at particular risk. The migrant worker shares low wages with the working poor; inadequate shelter with the homeless and those at risk of homelessness; are often not native to the areas in which they labor and may not be documented immigrants, a status they share with other immigrants; and, due to the high rate of injury in agricultural employment, may share limitations of function with those who are disabled.

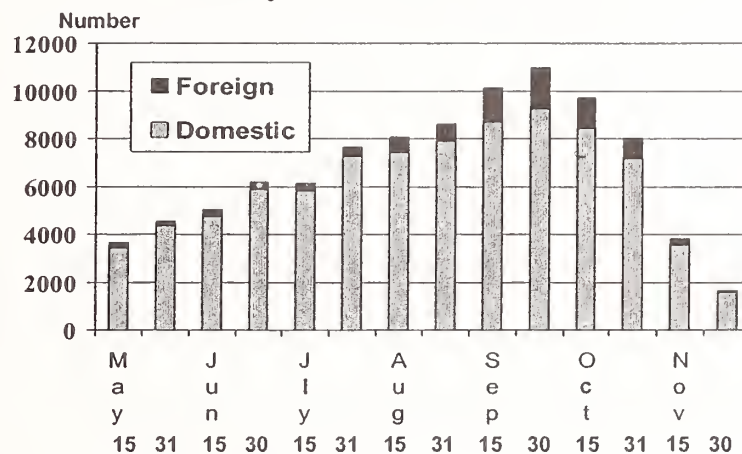
NYS Department of Labor Migrant and Seasonal Agricultural Worker Reporting Areas

- Hudson Valley
- Long Island
- Finger Lakes Region (Rochester)
- Champlain Valley
- Western NY (Buffalo)
- Central NY (Syracuse)

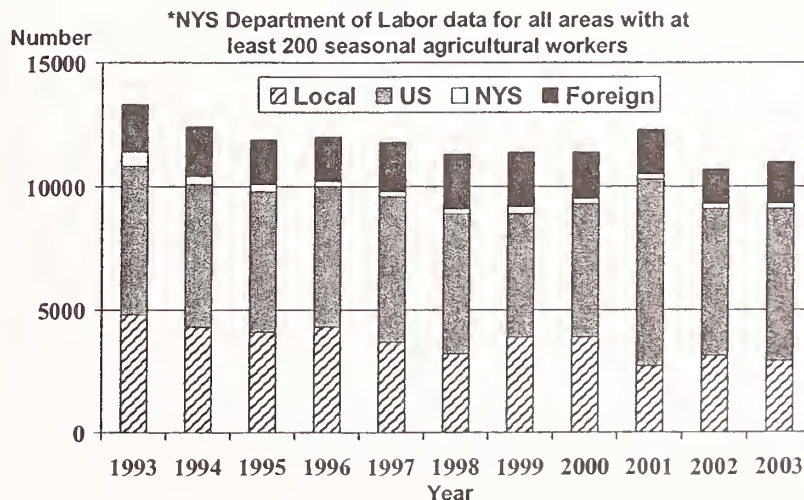
Seasonal Agricultural Worker Reporting Areas



Hired Seasonal Agricultural Workers
Employed at Semi-Monthly Reporting Periods
by Personal Origin - - NYS Peak Season
May - November 2003



NYS Hired* Seasonal Agricultural Workers
Employed during Annual Peak Period of
September 15-30



Persons of Transgender Experience

For purposes of this discussion, “Transgender” is an umbrella term for diverse gender expression which may include transsexuals, transvestites, drag queens/kings, or cross dressers and others who choose to self-identify as such.

Background

There exists only limited currently available data on HIV/AIDS risk behaviors and seroprevalence in the Transgender community. Small studies have been conducted in a number of large urban centers in the US. Together these studies have documented HIV infection levels higher among the Transgendered than those of the general public and comparable to or exceeding that of MSM or IDUs in the same geographical area.

One of the barriers to sound research on a larger scale is definition and identification of potential study participants. Fortunately, a great deal can be learned from these formal studies and from focus groups and conversations with key members of the community.

The complexities of Transgender HIV/AIDS risk *may* include:

- Bridging, through relationships, the political, social, sexual, and cultural space between and among gay men/MSM and lesbians, men and women of bisexual practice, and heterosexual men and women
- Possible exposure STDs, hepatitis and HIV by sexual partners or by customers through commercial sex work
- Risk of physical/sexual assault if placed within the criminal justice system
- Risk of injury or death through underground or unlicensed care for body modification
- Sharing needles to inject hormones, steroids, silicon, and/or drugs
- Commercial sex work without barrier use
- Avoidance of and/or denial of access to medical care due to Transgender status -- or -- being forced to revert to previous identity/status as a condition of access to care

- Stigmatization and/or discriminatory activities on the part of health care and service providers
- Poor care due to the lack of training in and knowledge of Transgender-related health concerns and needs
- Avoidance of barrier methods use as to do so might reveal identity/body/habitus* to others

* **Habitus** is a complex concept that can be understood as those aspects of culture that are anchored in the body or daily practices of individuals, groups, societies, and nations. It includes the totality of learned habits, bodily skills, styles, tastes, and other 'knowledges' that characterize -- but do not stereotype -- a specific group. [6]

Formative Research

New York State Bureau of HIV/AIDS Epidemiology and AIDS Institute staff, with the support and guidance of staff of Positive Health Project and Gender Identity Program, conducted a short series of focus groups in NYC in 2001. The goal of the groups was to solicit sufficient risk information to collaboratively develop with members of the Transgender community an HIV/AIDS risk survey instrument.

A brief summary of findings from the Focus Groups are as follows:

- Acceptable and respectful terminology: Transgender experience or Transgender spectrum were the preferred terms for self/community identification
- The range of HIV risk behaviors unique to this community include unprotected sexual practices, unsafe drug use, and the injection of hormones, steroids, and silicon/industrial products with the dual risk of transmission from reuse of used injection equipment and infection, illness, and death due to reaction to injected substances
- Activities associated with gender transition may increase risk of HIV transmission if delivered by untrained medical, non-medical, or black market practitioners offering underground services, medications and body enhancements
- Discrimination and harassment is frequent and harsh

References:

- [1] Dingle J¹, Stephens PC¹, Dzubilo C², "Uncharted Waters: Planning for an HIV Seroprevalence Study Among Individuals of Transgender Experience in New York," ¹Division of HIV Prevention, AIDS Institute, Albany, NY and ²Positive Health Project, New York, NY.
- [2] Center for Health Promotion and Wellness, Massachusetts Institute of Technology. "What does it mean to be Transgender?" (Brochure)
<http://web.mit.edu/medical/a-center.html>
- [3] National Coalition for LGBT Health, "An Overview of US Trans health Priorities: A Report by the Eliminating Disparities Working Group." August 2004 Update.
<http://www.nctequality.org/Health.asp>
- [4] National Coalition for LGBT Health, "Love Your Body: A Transwoman's Guide to Health and Wellness." <http://www.nctequality.org/Health.asp>
- [5] National Coalition for LGBT Health, "Love Your Body: A Transman's Guide to Health and Wellness." <http://www.nctequality.org/Health.asp>
- [6] Introduced by Marcel Mauss and further developed by Norbert Elias in the 1930s.
<http://en.wikipedia.org/wiki/Habitus>

Alcohol and Non-Injected Drug Use in NYS

A great deal of the data on non-injecting-related drug and alcohol use come from the criminal justice system including the courts, highway patrol and local police, the drug and alcohol recovery providers, and from emergency rooms. All gather the data for their own use and publish studies and summaries primarily for others in their same fields of endeavor.

PPG members, and, indeed, community members can put this data to good use in their prevention planning activities but must do so with one thought clearly in mind:

Data gathered for one purpose, no matter how carefully collected, analyzed, and reported, is *not* identical to the data, from the same group and setting, that was collected, analyzed and reported for another and different purpose.

That in mind, alcohol consumption and use of drugs by routes other than injection is not a direct risk for HIV infection. The indirect risk of drug or alcohol intake is the product of use and/or intoxication, i.e. the full or partial inability on the part of the individual to make decisions and to take actions to protect him or herself in the same way he/she would were he/she not intoxicated.

Some individuals use alcohol and/or drugs to:

- Help themselves to be less anxious about seeking or accepting sexual overtures or other behaviors beyond their typical patterns
- Make the sexual experience longer, better, easier for themselves and/or their partner(s)
- Urge others to engage in sexual or drug behaviors beyond their typical patterns

Additional health and HIV risk stems from the following:

- Drug and/or alcohol use or intoxication may exacerbate existing conditions both physical and mental
- Frequent use or intoxication may inference with family life, employment, education, travel, health care, nutrition, self-care, care of and/or interaction with others, and any other numbers of activities of daily life

Intoxication with drugs and or alcohol can also, in the same manner that operation of a motor vehicle is impaired, impair the individual's ability to manipulate safer sex and

safer drug use materials, procedures, and supplies, can impair their ability to travel to a safer location, and/or to a source for supplies.

The Office of Applied Studies, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, has published model-based estimates of drug, alcohol, and tobacco products usage by state. This data, describing all persons 12 years of age and older, is taken from the National Survey on Drug Use and Health.

The following tables are taken from this work. The states of New Jersey, Connecticut, Massachusetts and Pennsylvania are included for purposes of comparison as are the US and Washington DC estimates. Please note, some tables are repeated so that related data can be displayed in proximity to one another.

I. Any illicit drug or alcohol use in the past month:

Percentages of Persons Ages 12 and Older Reporting Use of ANY ILLICIT DRUG During the Past Month				
States/ Jurisdictions	All Persons 12 and Older	12 to 17	Ages 18 to 25	26+
NEW YORK	9.41	12.09	22.41	6.92
New Jersey	7.44	10.79	20.84	5.14
Connecticut	9.08	13.95	23.04	6.43
Pennsylvania	7.59	11.57	21.57	4.86
Massachusetts	8.54	16.02	24.63	5.09
Washington DC	12.43	12.43	28.50	9.36
US	8.30	11.63	20.19	5.79
Percentages of Persons Ages 12 and Older Reporting Use of ALCOHOL During the Past Month				
States/ Jurisdictions	All Persons 12 and Older	12 to 17	Ages 18 to 25	26+
NEW YORK	56.71	19.13	63.52	60.38
New Jersey	61.11	17.99	63.58	66.28
Connecticut	59.09	17.21	68.86	63.31
Pennsylvania	51.57	18.26	66.10	53.54
Massachusetts	60.34	20.16	68.05	63.90
Washington DC	58.97	13.68	69.19	61.01
US	50.96	17.63	60.47	53.91

II. Marijuana

Percentages of Persons Ages 12 and Older Reporting Use of MARIJUANA During the Past Month				
States/ Jurisdictions	All Persons 12 and Older	12 to 17	Ages 18 to 25	26+
NEW YORK	7.52	9.45	20.62	5.11
New Jersey	5.00	7.23	16.69	3.08
Connecticut	6.27	9.78	20.21	3.81
Pennsylvania	5.41	8.38	18.31	2.97
Massachusetts	6.32	10.92	21.69	3.32
Washington DC	10.82	10.48	27.71	7.53
US	6.20	8.17	17.33	4.01
Percentages of Persons Ages 12 and Older Reporting <i>PERCEPTION OF GREAT RISK</i> OF MARIJUANA USE Once a Month				
States/ Jurisdictions	All Persons 12 and Older	12 to 17	Ages 18 to 25	26+
NEW YORK	35.87	30.84	21.71	38.85
New Jersey	39.28	32.66	23.97	42.26
Connecticut	34.29	28.87	17.89	37.36
Pennsylvania	39.58	25.24	14.58	35.71
Massachusetts	24.89	27.59	13.85	26.33
Washington DC	32.42	31.13	17.21	35.51
US	38.37	32.41	23.54	41.76

II. Illicit Drug Use

Percentages of Persons Ages 12 and Older Reporting Use of ANY ILLICIT DRUG During the Past Month				
States/ Jurisdictions	All Persons 12 and Older	12 to 17	Ages 18 to 25	26+
NEW YORK	9.41	12.09	22.41	6.92
New Jersey	7.44	10.79	20.84	5.14
Connecticut	9.08	13.95	23.04	6.43
Pennsylvania	7.59	11.57	21.57	4.86
Massachusetts	8.54	16.02	24.63	5.09
Washington DC	12.43	12.43	28.50	9.36
US	8.30	11.63	20.19	5.79
Percentages of Persons Ages 12 and Older Reporting Use of ANY ILLICIT DRUG <i>Other than</i> Marijuana During the Past Month				
States/ Jurisdictions	All Persons 12 and Older	12 to 17	Ages 18 to 25	26+
NEW YORK	3.52	4.75	7.36	2.72
New Jersey	3.47	5.46	8.94	2.45
Connecticut	3.71	5.82	8.87	2.69
Pennsylvania	3.20	5.36	7.93	2.17
Massachusetts	3.73	7.61	10.64	2.71
Washington DC	4.39	4.17	9.18	3.46
US	4.38	4.75	8.47	3.67

III. Alcohol *Binge* Risk Perception and *Binge* Alcohol

Percentages of Persons Ages 12 and Older Reporting <i>PERCEPTION OF GREAT RISK</i> Of HAVING 5+ ALCOHOLIC DRINKS 1-2 Times a Week				
States/ Jurisdictions	All Persons 12 and Older	12 to 17	Ages 18 to 25	26+
NEW YORK	41.49	40.14	32.90	43.08
New Jersey	42.04	36.56	36.02	43.58
Connecticut	42.67	36.08	29.73	45.39
Pennsylvania	38.49	35.96	27.28	40.60
Massachusetts	35.78	35.52	27.04	37.20
Washington DC	45.76	44.58	36.87	47.62
US	42.34	38.24	33.18	44.50
Percentages of Persons Ages 12 and Older Reporting Use of <i>BINGE</i> ALCOHOL USE During the Past Month				
States/ Jurisdictions	All Persons 12 and Older	12 to 17	Ages 18 to 25	26+
NEW YORK	25.17	10.78	41.38	24.33
New Jersey	23.25	9.49	40.50	22.61
Connecticut	22.94	10.11	45.48	21.45
Pennsylvania	22.49	10.82	46.55	20.16
Massachusetts	25.71	13.97	42.28	24.48
Washington DC	26.85	7.60	44.17	25.17
US	22.87	10.67	40.93	21.44

Young People

Age does not confer risk or protection on an individual: the social context of a young person involved in a risky behavior may, however, place the young person at increased risk as compared to an older person.

Statistical and social markers of risk among young people include but are not limited to:

- Teen pregnancy/Out-of-wedlock births
- STD/STIs
- Abortion
- Alcohol and drug use/Treatment
- School drop-out rates
- Involvement with Juvenile and Criminal Justice systems
- Larger age differences between the young person and their sexual partner(s)
- Multiple and concurrent sexual partners/relationships

Schuster and colleagues distributed an anonymous, self-administered survey of 2,026 urban students in grades 9 through 12 to determine if high school-aged virgins engage in practices that could transmit HIV and STD/STIs.

Selected findings include:

- 47% of respondents were virgins: 42% of males and 53% of females
- Of those who were virgins, in the past year 29% had engaged in heterosexual masturbation of a partner and 32% had been masturbated by a partner
- Corresponding rates for heterosexual fellatio with ejaculation, cunnilingus, and anal intercourse were 9%, 10% and 1% respectively
- Homosexual sexual activities were rare ~ 1%
- Condom use for fellatio was rare

Level of risk in sexual behavior of virgins was associated with illicit substance use and other risky behaviors even after control for demographic variables.

The investigators concluded:

- Few high school-aged virgins engaged in anal intercourse but many engaged in other genital sexual activities
- Some of these activities can transmit HIV and/or STD/STIs
- All indicate a need for counseling about sexual decision-making, risk, and prevention

Resources

Schuster MA, Bell RM, and Kanouse DE, "The Sexual Practices of Adolescent Virgins: Genital Sexual Activities of High School Students Who Have Never Had Vaginal Intercourse," *AJPH*. November 1997: Vol. 86, No. 11.

Direct and Indirect Markers of HIV Risk



The Importance of Certain Communicable Diseases when in Conjunction with HIV

Certain sexually transmitted diseases (STDs), such as gonorrhea and Hepatitis B (HBV) share routes of infection. In these situations, infection with these STD/STIs can indicate the presence of risky behavior in HIV-negative persons and are an indication of unsafe, non-barrier sexual activity among HIV-positive persons.

Other infections or diseases may potentiate infection or transmission. Infections known as GUD, or genital ulcer disease, increase the risk of acquiring or transmitting HIV by causing breaks in normally intact genital tissue and/or increasing the number of white blood cells, including CD4+ cells targeted by HIV, at the local site of infection.

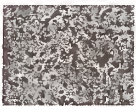

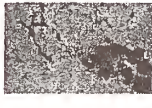
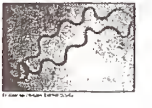
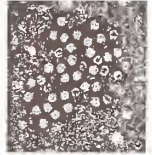
Communicable diseases, such as tuberculosis (TB), are more likely to be contracted by immune-compromised persons such as those living with HIV/AIDS, other serious immunodeficiency diseases, and after organ transplant or some cancer treatments. Additionally, some persons at risk for HIV may live in substandard, poorly ventilated, and/or crowded housing increasing the chances of TB transmission if one or more residents are actively infected and unmedicated or inadequately medicated.

Other diseases, such as malaria, schistosomiasis, dengue, or any of the other diseases that plague the peoples of developing countries may not directly interact with HIV on the biological level but certainly contribute to difficulty and increased cost of treatment and the overall burden of disease on the individual and on the community.

The following information on STDs, hepatitis, and TB in New York State is a brief, simplified description of the various infections and their relationships and/or interactions with HIV.

Further information on frequency, location, and demographics is displayed in the tables and graphs in this section.

Selected Communicable Diseases among Adolescents and Adults: A Brief Description*

Infection or Disease	Agent/ Organism (Image***)	Mode of Transmission	Symptoms	Treatment	Prevention	Relationship to HIV
Chlamydia	<i>C. trachomatis</i> (bacteria) 	Sexually transmitted	<u>Males:</u> Urethritis, proctitis <u>Females:</u> Cervicitis	Antibiotics	Health & sex education; Condom use, Routine screening	May be co-transmitted with HIV; may increase transmission rate; Marker for unprotected sexual contact
LGV Lympho-granuloma venereum	<i>C. trachomatis</i> (bacteria) 	Sexually transmitted. NB: In 2004 CDC reported numerous cases among MSM and bisexual men in Northern Europe and expect numbers to increase in US.	Tenderness of groin nodes, possible genital ulcer, anal pain, stricture, Inflammation.	Antibiotics	Health & sex education; Condom use	May be co-transmitted with HIV; may increase transmission rate; marker for unprotected sexual contact; <u>CDC alert re:</u> possible outbreak among MSM and bisexual men
Gonorrhea	<i>N. gonorrhoeae</i> (bacteria) 	Sexually transmitted	<u>M:</u> Urethral pain and discharge <u>E:</u> Cervicitis, PID <u>Both M/F:</u> Pharyngeal, anorectal infection	Antibiotics	Health & sex education; Condom use, Routine screening	May be co-transmitted with HIV; may increase transmission rate; Marker for unprotected sexual contact.
Syphilis	<i>T. pallidum</i> (spirochete) 	Sexually transmitted	**1 ^o lesion; 2 ^o rash, 3 ^o latency, CNS, skin, bone, organ involvement	Antibiotics	Health & sex education; Condom use, Routine screening	May be co-transmitted with HIV; may increase transmission rate; Marker for unprotected sexual contact.
HAV Hepatitis A Virus	Hepatitis A Virus (picornavirus) 	Person-to-person via fecal-oral route. Can include drug injection, anal sex, day care center employees, travelers.	Abrupt with fever, malaise, anorexia, Nausea, abdominal discomfort; jaundice follows in a few days.	No specific treatment. Follow-up, investigation of all outbreaks. Track to index case And screen/prophylax contacts.	Good hygiene (hand-washing), good sanitation, water treatment. Vaccination. Postexposure prophylaxis.	May be co-transmitted with HIV; may increase transmission rate; Marker for unprotected sexual contact.

HBV Hepatitis B Virus <div data-bbox="331 310 491 415" data-label="Image"> </div>	Hepatitis B Virus (hepadnavirus)	Contact with infected body fluids; sexual transmission; occasional in- direct contact with innate objects previously innoculated with infected body fluids.	Insidious, anorexia, vague abdominal discomfort, nausea and vomiting, joint/bone pain and rash, eventual jaundice	Antiviral drugs. Follow-up, investigation of all out- breaks. Track to index case And screen/ prophylax contacts. Postexpo- sure pro- phylaxis for exposures.	Infant and at-risk (MSM, drug injectors, health care workers) vaccination, sterilize or discard used medical equipment, screen blood and blood products. Condom use.	May be co- transmitted with HIV. May make medication choice/use more difficult.
HCV Hepatitis C Virus <div data-bbox="331 772 481 928" data-label="Image"> </div>	Hepatitis V virus (Hepacavirus)	Contact with infected body fluids; sexual transmission; injection drug use; reuse or use of unsterile medical equipment, tattooing.	Asymptomatic Or insidious with anorexia, vague abdominal discomfort, nausea and vomiting, joint/bone pain and rash, less jaundice.	Antiviral drugs. Follow-up, investigation of all cases.	Infant and at-risk (MSM, drug injectors, health care workers) vaccination, sterilize or discard used medical equipment, screen blood and blood products. Condom use.	May be co- transmitted with HIV. May make medication choice/use more difficult. 50-80% develop chronic infection; Potential progression to cirrhosis or hepatocellular cancer.
TB Tubercu- losis <div data-bbox="322 1423 481 1537" data-label="Image"> </div>	<i>M. tuberculosis</i> complex: <i>M. Tubercu- losis</i> , <i>M. africanum</i> , <i>M. bovis</i> [from cattle]. (mycobacteria)	Airborn droplets from coughing, singing, sneezing	Fatigue, fever, weight loss, night sweats then cough, chest pain, bloody sputum, and hoarseness	Antibiotics	Public education, Routine screening, prompt diagnosis, correct treatment, DOT as necessary, improved housing, increased ventilation. Well-sup- ported case finding/ treatment centers	10-80% of HIV+ persons with latent TB will develop active TB in lifetime; Co-pandemic of HIV/TB in 1980-90s
* Pregnancy, birth, and childhood aspects of the above diseases are <i>not</i> included on this table. ** 1 ^o , 2 ^o , 3 ^o = Primary, secondary, tertiary stages of syphilis *** All images are of human-disease causing agents; photos are of tissue samples						

References:

[1] Centers for Disease Control and Prevention, STD Fact Sheets
Available at: www.cdc.gov/std/chlamydia/STDFact-Chlamydia.htm
www.cdc.gov/std/gonorrhea/STDFact-Gonorrhea.htm
www.cdc.gov/std/syphilis/STDFact-Syphilis.htm
www.cdc.gov/ncidod/diseases/hepatitis/a/fact.htm
www.cdc.gov/ncidod/diseases/hepatitis/b/fact.htm
www.cdc.gov/ncidod/diseases/hepatitis/c/fact.htm
www.cdc.gov/nchstp/tb/faqs/qa_TB_Disease.htm

[2] Chin J, Editor, Control of Communicable Diseases Manual. American Public Health Association, Washington DC, 17th Edition, 2000.

[3] Images adapted from www.google.com/images

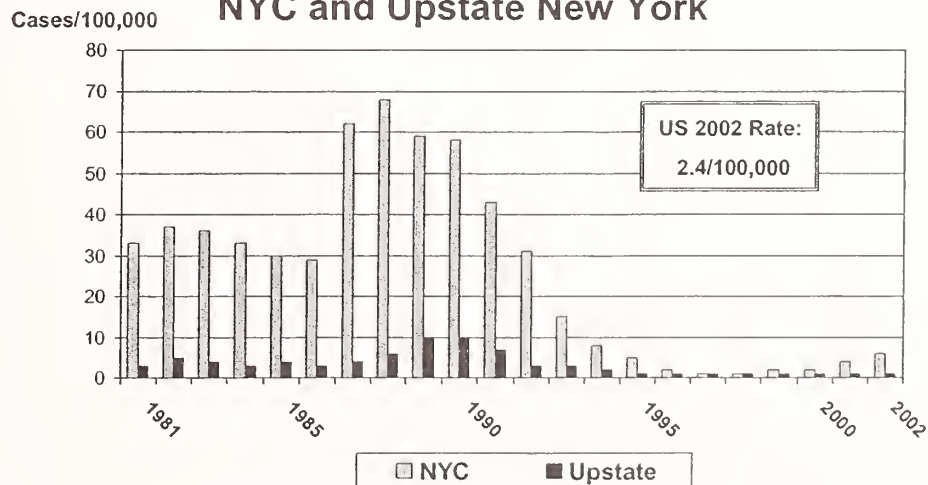
Primary and Secondary Syphilis, Gonorrhea, Chlamydia



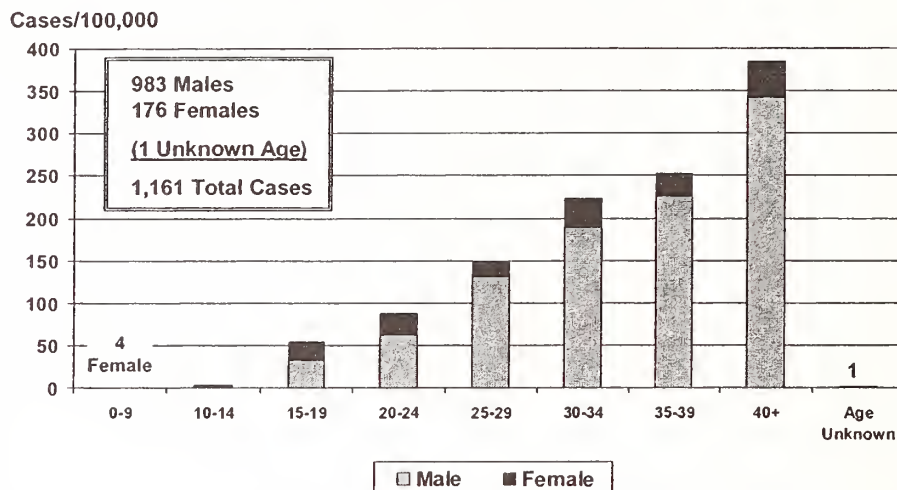
Additional materials based on the
2003 Statistical Abstract
Sexually Transmitted Disease Control Program
NYSDOH

Primary and Secondary Syphilis by Cases per 100,000 Population 1981 through 2002

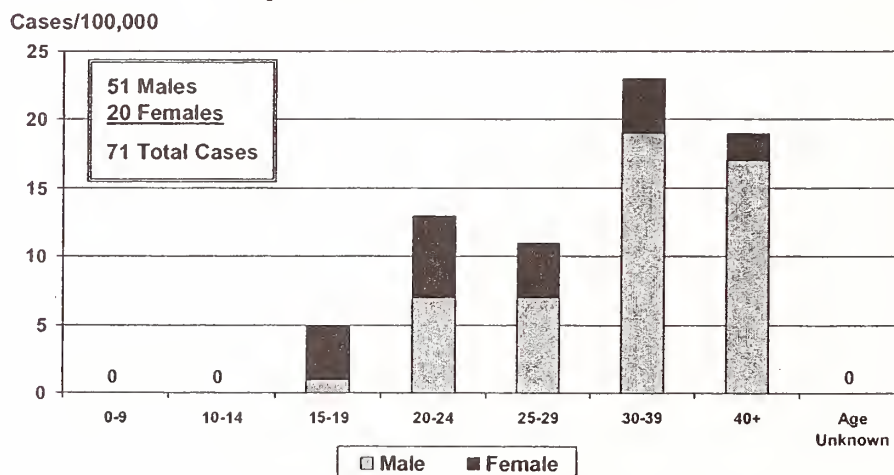
NYC and Upstate New York



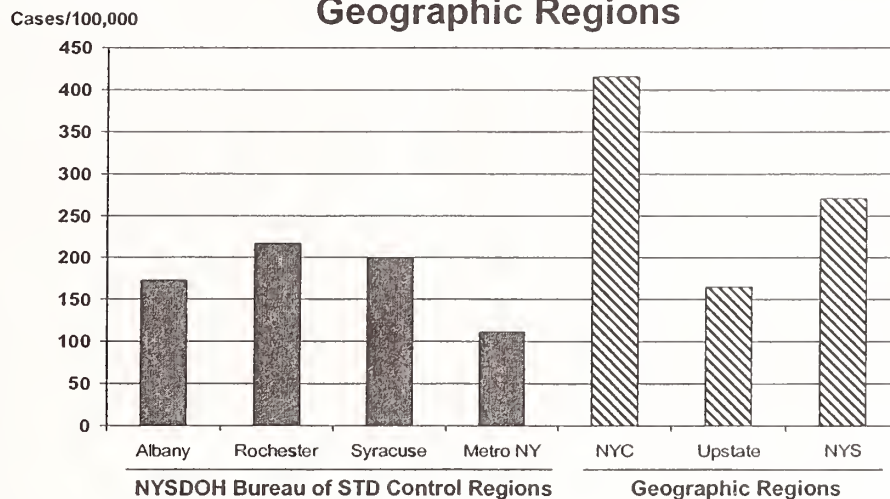
Syphilis Cases by Gender and Age Group at Diagnosis New York City -- 2002



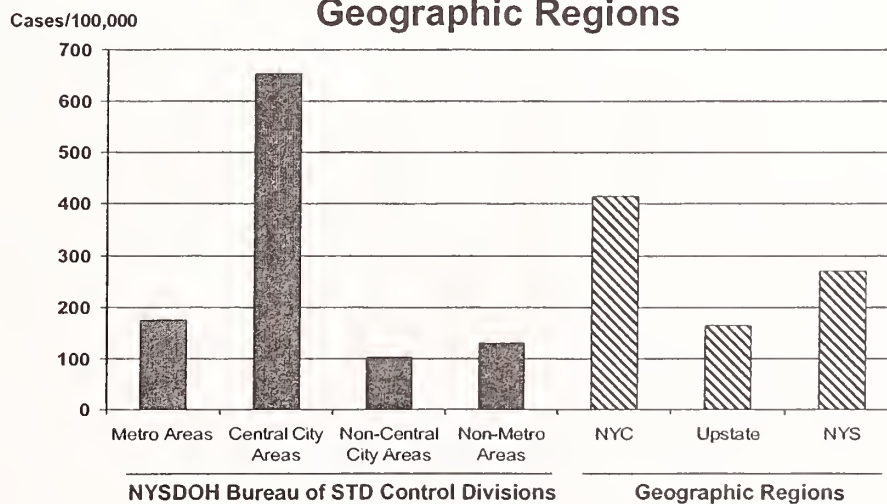
Syphilis Cases by Gender and Age Group at Diagnosis Upstate New York -- 2002



Chlamydia in NYS – 2002 Cases per 100,000 Population by Bureau of STD Control Regions and Geographic Regions

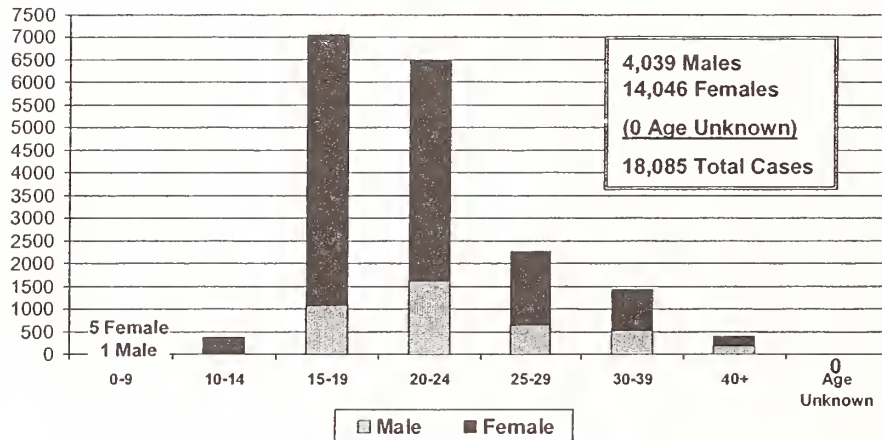


Chlamydia in NYS – 2002 Cases per 100,000 Population by Bureau of STD Control Regions and Geographic Regions



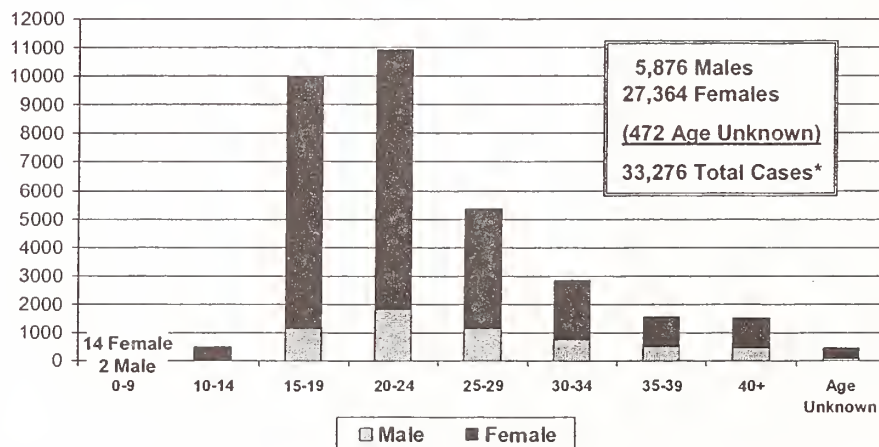
Chlamydia Cases by Gender and Age Group at Diagnosis Upstate New York -- 2002

Cases/100,000



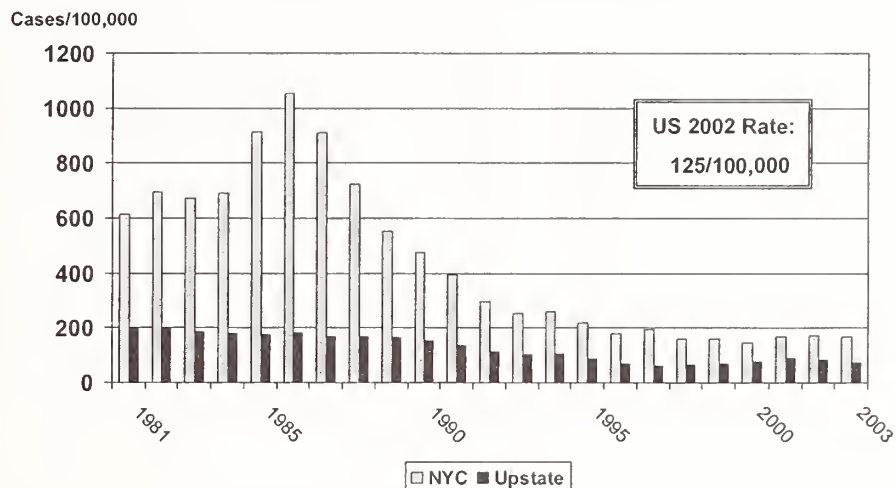
Chlamydia Cases by Gender and Age Group at Diagnosis New York City -- 2002

Cases/100,000

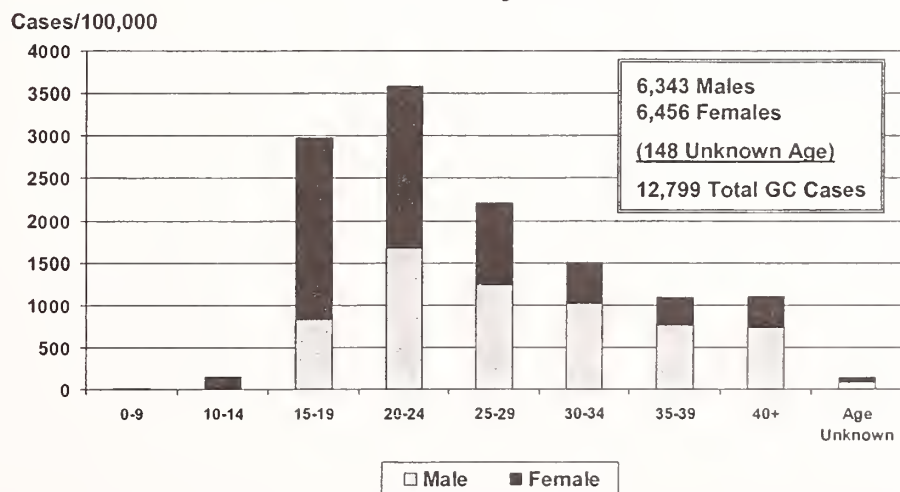


* Total includes 36 individuals for whom gender is unknown

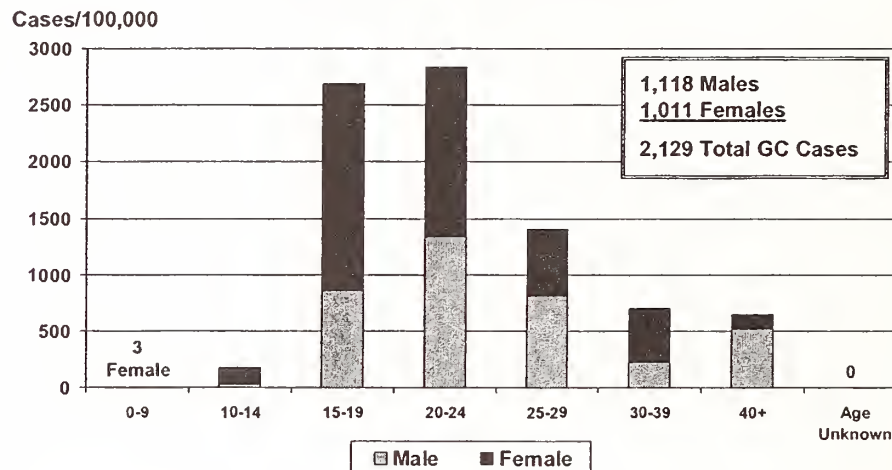
Gonorrhea by Cases per 100,000 Population 1981 through 2002 NYC and Upstate New York



Gonorrhea Cases by Gender and Age Group at Diagnosis New York City -- 2002



Gonorrhea Cases by Gender and Age Group at Diagnosis Upstate New York -- 2002



Selected Communicable Diseases of Concern in HIV/AIDS Prevention													
Geographic Region	Sexually Transmitted Diseases						Hepatidities						Tuberculosis
NYS Counties	Gonorrhea		Early* Syphilis		Chlamydia		HAV		Acute HBV		Acute HCV		TB
	# Cases	Rate per 100,000	# Cases	Rate per 100,000	# Cases	Rate per 100,000	# Cases	Rate per 100,000	# Cases	Rate per 100,000	# Cases	Rate per 100,000	# Cases
Albany	511	172.5	1	0.3	920	310.6	5	1.7	3	1.0	1	0.3	8
Allegany	3	6.0	0	0.0	61	121.6	1	2.0	0	0.0	0	0.0	0
Broome	99	49.4	5	2.5	453	226.1	0	0.0	0	0.0	0	0.0	6
Cattaraugus	7	8.4	1	1.2	39	46.8	0	0.0	0	0.0	0	0.0	1
Cayuga	27	33.1	0	0.0	123	150.8	0	0.0	0	0.0	0	0.0	2
Chautauqua	61	44.1	0	0.0	277	200.2	1	0.7	0	0.0	0	0.0	0
Chemung	131	144.6	0	0.0	210	231.8	1	1.1	3	3.3	0	0.0	0
Chenango	2	3.9	0	0.0	54	105.2	0	0.0	0	0.0	0	0.0	2
Clinton	29	35.8	0	0.0	135	166.5	0	0.0	0	0.0	0	0.0	1
Columbia	31	48.8	1	1.6	79	124.4	0	0.0	1	1.6	1	1.6	2
Cortland	10	20.5	0	0.0	74	151.6	1	2.1	0	0.0	0	0.0	0
Delaware	3	6.3	0	0.0	35	74.0	0	0.0	0	0.0	0	0.0	0
Dutchess	207	71.9	4	1.4	408	141.8	5	1.7	5	1.7	3	1.0	7
Essex	1,572	166.3	4	0.4	2,985	315.9	9	1.0	8	0.9	2	0.2	21
Franklin	2	5.1	0	0.0	27	69.4	1	2.6	0	0.0	0	0.0	2
	4	7.9	0	0.0	51	100.1	1	2.0	1	2.0	1	2.0	1
Fulton	8	14.5	1	1.8	103	187.1	0	0.0	0	0.0	2	3.6	0
Genesee	14	23.4	0	0.0	46	76.9	1	1.7	1	1.7	0	0.0	0
Greene	4	8.2	1	2.1	45	92.7	0	0.0	1	2.1	0	0.0	0
Hamilton	0	0.0	0	0.0	2	37.8	0	0.0	0	0.0	0	0.0	0
Herkimer	12	18.8	0	0.0	65	102.0	0	0.0	2	3.1	2	3.1	0
Jefferson	59	54.6	0	0.0	305	282.0	0	0.0	0	0.0	0	0.0	0
Lewis	2	7.5	0	0.0	18	67.5	0	0.0	0	0.0	0	0.0	0
Livingston	6	9.3	0	0.0	86	132.7	1	1.5	0	0.0	0	0.0	1
Madison	11	15.8	0	0.0	85	121.8	1	1.4	0	0.0	0	0.0	0
Monroe	1,820	246.5	15	2.0	3,715	503.1	4	0.5	21	2.8	0	0.0	22
Montgomery	6	12.2	0	0.0	48	97.2	1	2.0	1	2.0	4	8.1	0
Nassau	440	32.7	16	1.2	1,678	124.8	31	2.3	14	1.0	1	0.1	56
Niagara	237	108.7	0	0.0	528	242.1	3	1.4	1	0.5	0	0.0	3
Oneida	245	104.3	6	2.6	460	195.8	3	1.3	8	3.4	2	0.9	5
Onondaga	1,001	217.2	1	0.2	2,067	448.6	5	1.1	7	1.5	0	0.0	19
Ontario	20	19.7	0	0.0	130	128.0	4	3.9	1	1.0	1	1.0	1
Orange	150	42.0	2	0.6	496	139.0	5	1.4	2	0.6	0	0.0	14
Orleans	15	34.2	0	0.0	73	166.3	2	4.6	0	0.0	0	0.0	2
Oswego	8	6.5	0	0.0	138	112.3	0	0.0	3	2.4	0	0.0	1
Otsego	6	9.7	0	0.0	74	119.2	1	1.6	0	0.0	0	0.0	0
Putnam	10	10.2	3	3.1	37	37.7	0	0.0	0	0.0	0	0.0	1
Rensselaer	127	82.8	2	1.3	279	182.0	4	2.6	2	1.3	0	0.0	1
Rockland	57	19.5	4	1.4	360	123.4	3	1.0	3	1.0	0	0.0	23
St. Lawrence	11	9.9	0	0.0	117	105.2	1	0.9	0	0.0	0	0.0	0
Saratoga	37	17.9	0	0.0	210	101.4	1	0.5	1	0.5	0	0.0	1
Schenectady	183	124.4	1	0.7	462	314.0	3	2.0	2	1.4	1	0.7	2
Schoharie	3	9.4	0	0.0	28	87.9	0	0.0	0	0.0	0	0.0	0
Schuyler	5	25.8	0	0.0	14	72.3	0	0.0	0	0.0	0	0.0	0
Seneca	3	8.6	0	0.0	36	102.9	0	0.0	2	5.7	0	0.0	1
Steuben	20	20.1	0	0.0	106	106.7	1	1.0	1	1.0	0	0.0	2
Suffolk	470	32.2	21	1.4	1,572	107.8	27	1.9	4	0.3	4	0.3	61
Sullivan	35	47.1	2	2.7	130	175.0	0	0.0	1	1.4	0	0.0	2
Tioga	4	7.7	0	0.0	48	92.7	0	0.0	0	0.0	0	0.0	1
Tompkins	15	15.1	1	1.0	183	184.5	3	3.0	1	1.0	0	0.0	4
Ulster	99	55.0	3	1.7	285	158.4	3	1.7	5	2.8	0	0.0	2
Warren	8	12.5	0	0.0	69	108.0	0	0.0	0	0.0	0	0.0	2
Washington	5	8.2	0	0.0	53	86.6	0	0.0	0	0.0	0	0.0	0
Wayne	36	38.3	0	0.0	138	146.7	0	0.0	0	0.0	0	0.0	3
Westchester	591	63.1	19	2.0	1,595	170.2	13	1.4	5	0.5	0	0.0	57
Wyoming	0	0.0	0	0.0	23	53.3	0	0.0	0	0.0	1	2.3	0
Yates	2	8.2	0	0.0	16	65.2	0	0.0	0	0.0	0	0.0	0
New York State exclusive of New York City	8,484	76.6	114	1.0	21,854	197.4	146	1.3	110	1.0	26	0.2	340
New York City	13,326	164.8	1,482	18.3	34,497	426.7	446	5.5	204	2.5	na	na	1,140
New York State	21,810	113.8	1,596	8.3	56,351	294.1	592	3.1	314	1.6	na	na	1,480

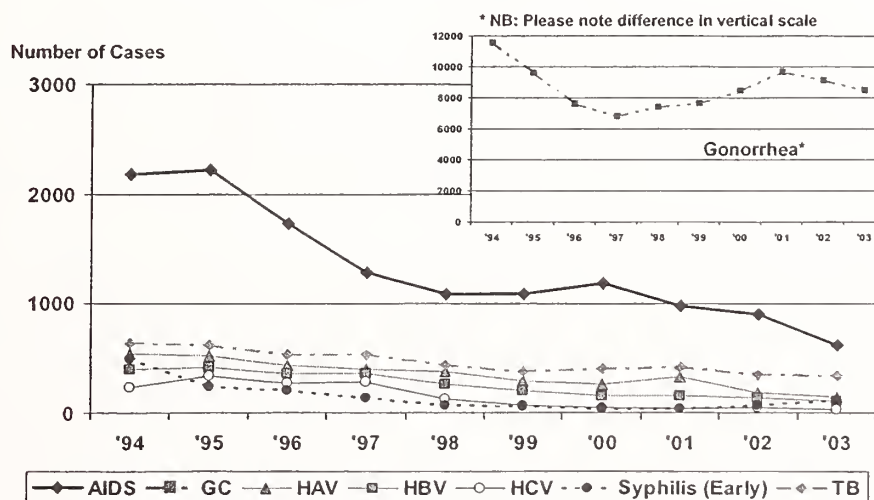
* Early Syphilis = Primary and secondary syphilis

Trends in Selected Communicable Diseases by Geographical Distribution

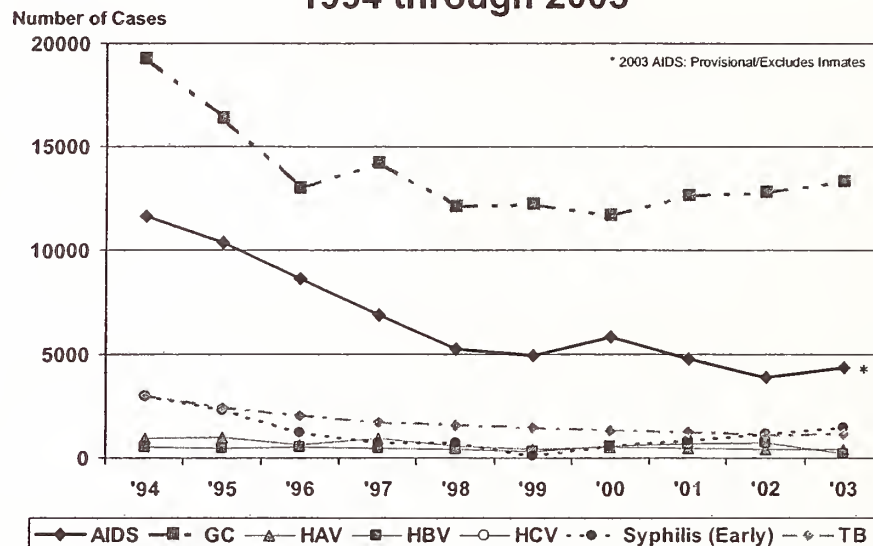


AIDS, Gonorrhea, Hepatitis A, B, and C, Syphilis
and Tuberculosis 1993 through 2003

Trends in Selected Communicable Diseases New York State (Exclusive of New York City) 1994 through 2003



Trends in Selected Communicable Diseases New York City 1994 through 2003



Tuberculosis in New York State

Tuberculosis in New York State, a publication of the Bureau of Tuberculosis Control, New York State Department of Health, describes the current situation as:

- In 2003, tuberculosis morbidity increased slightly in New York State. The 2003 figure of 1,480 (1,140 cases in New York City, 340 cases in the remainder of New York State) represents a 3.2 percent increase from the 2,434 cases reported in 2002 and a 67.6 percent decline from 1992, the recent peak epidemic year with 4,574 cases. The nation as a whole experienced a 1.4 percent decline in reported cases between 2002 and 2003 (15,075 in 2002; 14,871 in 2003) and a 44.3 percent decline since 1992.
- In New York State (exclusive of New York City), the number of TB cases decreased 2.9 percent from 2002 to 2003 (305 cases to 340 cases). The number of TB cases increased by 5.2 percent in New York City from 2002 to 2003 (1,084 cases to 1,140 cases).
- New York State ranked fifth nationally (behind the District of Columbia, Hawaii, and Alaska) with a case rate of 7.8 per 100,000 population in 2003. This rate is influenced by New York City, which had a TB case rate of 14.2/100,000. In contrast, New York State (exclusive of New York City) reported an incidence rate of 3.1/100,000. The national average was 5.1/100,000.
- Three counties -- Nassau, Suffolk, and Westchester -- reported over half of the TB morbidity in New York State (exclusive of New York City) in 2003.
- In New York State (exclusive of New York City), during 2003, a higher proportion of cases occurred among individuals 65 years or older (22.4%) compared to New York City's proportion (14.2%) in this age group. Blacks, Hispanics, and Asians had higher rates of TB compared to whites, both in New York City and the rest of the state.
- Among individuals with drug susceptibilities reported in 2003, the number of multiple drug-resistant (MDR-TB) cases in New York City decreased from 27 in 2002 to 21 in 2003. In New York State (exclusive of New York City), there were 6 MDR-TB cases in 2003 compared to 3 in 2002, 6 in 2000, 1 in 1999, 4 in 1998, and 5 in 1997.

The following demographics, adapted from the same report, describe the impact of TB on specific age groups, communities of color, and other segments of the NYS population:

- Thirty-three children under the age of 5 were diagnosed with active TB in 2003, a decrease from 38 cases reported the previous year.
- In New York City the highest rates occurred in the 35-44 and the 45-54 year age groups at 20.8 and 18.6/100,000 respectively. At 5.3/100,000 cases per 100,000, those ages 25-34 experienced the highest rate in the remainder of the state.
- Statewide, the TB incidence rate among males was 1.8 times the rate among females (10.0 compared to 5.7/100,000).
- During 2003, the largest proportion of cases occurred among Blacks, followed by Hispanics, Asians, and Whites. The rates in all of the communities of color have increased from 2002 to 2003.
- The proportion of statewide cases contributed by the foreign-born increased slightly to 66.1 percent. In New York State (exclusive of New York City), half of the foreign-born cases originated from the Caribbean or Central or South America.
- During the late 1980s and early 1990s a substantial proportion of cases reported in New York State (exclusive of New York City) were in the New York State Department of Correctional Services (DOCS) inmate population. Since that time there has been a notable decline such that in 2003, only three cases were reported among inmates.
- In 2003, 61.7 percent of TB cases had a known and reported HIV status. 8.8 percent of all cases were HIV-positive; 53.9 were HIV-negative; and HIV status was unknown for the remaining 38.3 percent.
- The number of MDR-TB cases decreased from 27 in 2002 to 21 in 2003.
- Pulmonary tuberculosis was the primary site of disease in 73.4 percent of cases reported in 2003 in New York State. Lymphatic TB disease was the next most frequently observed site at 10.9 percent of the 2003 total.
- Of the 329 non-MDR-TB cases who were alive at diagnosis in 2002, 84.5 percent completed a full course of therapy with a completion index of 96.5.
 - Completion Index = number completed/(number alive at diagnosis - number died on treatment - number moved out of jurisdiction).

- In 1991, 297 cases or 45.2 percent of individuals with confirmed TB and on TB medications received at least a part of their therapy as directly observed. This proportion has increased over time with 92.7 percent in 2003 receiving DOT (directly observed therapy) services for all or a part of their therapy.

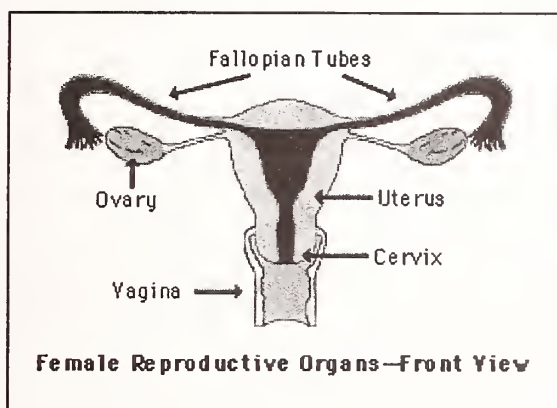
References

- [1] Bureau of Tuberculosis Control, *Tuberculosis in New York State: 2003 Annual Statistical Report*. New York State Department of Health, Albany, 2004.

Cervical Cancer

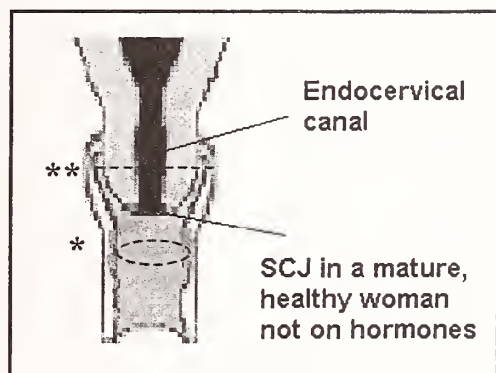
Background

Prior to the introduction of the Papanicolaou Smear in 1943, there was no method available to detect cervical cancer in women until the disease was in an advanced stage and/or became visible to a clinician during a pelvic exam. The pap smear, named after the developer, George Papanicolaou [1], gathers cells from the face of the cervix and the endocervical canal, the narrow channel extending from the interior of the uterus into the vagina.



The endocervical canal and the face of the cervix comprise the location where cells of the interior lining of the uterus, columnar cells, meet the cells that line the vagina, squamous cells. This site, known as the transformation zone or the SCJ (squamo-columnar junction) changes over the life of the individual woman as she matures sexually, is affected by hormonal and other treatments including birth control pills, and is a target for attachment and/or colonization

by STD/STIs including herpes, gonorrhea, and HPV (Human Papilloma Virus or venereal warts). [1] Some, particularly HPV, can be identified by Pap smear.



In a young woman, before, during, and extending for a period of time immediately after puberty, the SCJ is typically found on the vaginal walls (*) or on the body of the cervix (**). Birth control pills modify the cells of the cervix and vagina; the SCJ is typically located on the body of the cervix similar to that of younger women. [2] This condition is called ectopy.

An understanding of the “geography” of ectopy is vitally important to preventing infection by HIV and other STD/STIs. The columnar cells are more vulnerable to such infections than are the squamous cells that line the vagina. Some STD/STIs have evolved to take advantage of this difference. For example, gonorrhea deposited in the vagina during intercourse sends out extremely long, slender threads called pili that differentially attach to columnar cells. Once attachment is made the pilus contracts literally pulling the gonococcus cell up into the region of columnar cells where the cell can colonize and reproduce. [3] Herpes, HSV, is likewise attracted to the transition zone as here an increased rate of cellular growth occurs, an environment conducive to viral reproduction.

Cervical Cancer Statistics

The connection of HPV and cervical cancer was first reported in 1975-6 by Zur Hausen and colleagues. Cervical cancer is now recognized as the most frequent female malignancy in the less developed countries and a major concern world-wide.

In the US, the National Vital Statistics System and the National Cancer Institute compile and compare national and local cervical cancer death rates. From 1997 through 2001, the US experienced the loss of an average of 4,267 women each year to cervical cancer; NYS lost 316 women annually. During this same time period the US annual death rate for cervical cancer was 2.9 deaths per 100,000 females (all races and ages). The same rate for New York State was slightly higher at 3.0 per 100,000 females.

Comparing NYS counties with national trends, the following characterizations can be made:

- NYS has no counties where the cervical cancer rate is rising *and* that rate exceeds the US rate
- Bronx and Kings County (Brooklyn) have stable rates of cervical cancer however, those rates are above the US mean rates
- Rockland County has a relatively stable rate which is very similar to national rates of cervical cancer
- Nassau County has a stable rate and that rate is below rates for cervical cancer in the US
- New York County (Manhattan) has a falling rate of cervical cancer however, that rate remains above that of the US
- The following counties, and the whole of NYS, have a decreasing rate of cervical cancer and which, at this point in time, is very similar to US rates
 - ~ New York State
 - ~ Albany County
 - ~ Monroe County
 - ~ Niagara County
 - ~ Orange County
 - ~ Queens County (Queens)
 - ~ Suffolk County
- These NYS counties have falling rates of cervical cancer and these rates are lower than the US mean rate:
 - ~ Erie County
 - ~ Onondaga County
 - ~ Westchester County

The remaining counties in NYS were either were suppressed (censored) to protect patient confidentiality or had such low cervical cancer case rates that rates were considered unreliable.

Fortunately, death is not the only outcome of a diagnosis of cervical cancer. Many women can be treated as an out-patient with a procedure that involves only slightly more tissue removal and/or treatment than the actual cancerous lesion. Women with pre-cancerous lesions are also treated in this same manner to prevent future problems. As the size, depth and location of the lesion increase, more extensive surgical procedures, with or without chemotherapy/radiation, are employed and may include partial or complete hysterectomy.

Cervical cancer is fully preventable and curable, at low cost and at low risk, when screening to facilitate the timely detection of early precursor lesions in asymptomatic women is available together with appropriate diagnosis, treatment and follow-up.

PAHO, 2004

Prevention is relatively simple: Regular and timely pap smears collected by a trained clinician and read by an experienced screener at a reputable laboratory. The American Cancer Society recommends that pap smears and HPV screening begin within 3 years of the onset of vaginal intercourse or, at least, by age 21. Frequency of screening at a rate less than annually is controversial and screening frequency should be determined by the individual woman and her clinician taking into account her personal risk factors and those of the communities from which come her sexual partner(s).

Cervical Cancer, HIV, and HPV

HPV is present in an extremely large proportion of HIV-positive women. This high prevalence of co-infection is associated with young age at onset of vaginal intercourse, presence of other STD/STIs, and multiple sexual partners. In cervical/vaginal washings and anal swabs, respectively, Hillemanns and Chiasson detected HPV DNA *15 times* more often in HIV-positive women as compared to similar non-HIV-infected women making HIV a risk factor for HPV. [5] [6] Each infection appears to augment or potentiate the other: at the 1997 National Conference on Women and AIDS, the highest levels of HIV were cultured from cervicovaginal fluids of a woman with *treated* HVP. [7] In 1992 Hankins et al. demonstrated a high prevalence and increased severity of genital tract infection in HIV-infected women. [8] By 1993, these various and mutual associations were so clear that CDC included invasive cervical cancer as an AIDS-defining illness in an HIV-positive woman. [9]

It has been suggested in the literature [10] that the microenvironment of the endocervical canal and the cervical os (opening from the endocervical canal to the vaginal vault) is ideal for the accelerated proliferation of HVP, particularly the types more likely to produce dysplasia and eventual cancer. Further it is postulated that activated endocervical macrophages (white blood cells) may enhance HIV replication. These cells cluster mainly in the transformation zone (discussed earlier) and tend to dominate early colonies of HIV in infections acquired through sexual exposure.

Investigating the larger social environment, Quinlivan and colleagues reported that among 457 teenage mothers in Melbourne, Australia, the number of abnormal pap smears

were high. Teen mothers with an abnormal pap were more than 7 times more likely to have a history of exposure to domestic violence than were teen mothers with normal pap smear results. The abnormal pap result group was also more than 6 times as likely to be homeless, more than 5 times as likely to have co-existing Chlamydia, and approximately 3 times as likely to have a history of or current use of illegal drugs than the negative pap group of teen mothers. [11, 12]

Immigrant Women

HPV and cervical cancer morbidity and mortality occur at varying rates community to community, country to country, and region to region. Some variance is due to access to screening, diagnosis, and treatment. Other variation can also be a result of factors including but not limited to:

- Local and/or cultural differences in sexual practice norms
- Types and prevalence levels of STD/STIs
- Women's rights
- Availability of trained health workers
- Transportation
- Religious strictures
- Culturally mandated body modification
- Length of time in NYS/US

In communities of NYS where large numbers of immigrants first make their homes and/or reside, the level of screening, diagnosis, and care required for optimum cervical health may better reflect the needs of the country of origin than the current need levels for NYS.

Resources

- [1] <http://www.clevelandclinic.org/health/health-info/pictures/femrepr.gif>
- [2] Adapted from
<http://www.clevelandclinic.org/health/health-info/pictures/femrepr.gif>
- [3] Lutwick LI et al. Gonococcal Infections. 2004.
<http://www.emedicine.com/med/topic922.htm>
- [4] Nicol AF, Gomes Fernandes AT, and Bonecini-Almolda MdaG. Immune response in cervical dysplasia induced by human papillomavirus: the influence of human immunodeficiency virus – 1 co-infection – Review. 2005. *Mem. Inst. Oswaldo Cruz* 100(1).
- [5] Hillemanns P, Ellerbrock TV, et al. Prevalence of anal human papillomavirus infection and anal cytologic abnormalities in HIV-Seropositive women. 1996. *AIDS*. 10:1641-1647.
- [6] Chiasson MA, Ellerbrock TV, et al. Increased prevalence of vulvovaginal condyloma and vulvar intraepithelial neoplasia in women infected with the human immunodeficiency virus. 1997. *Obstetrics and Gynecology*. 89:690-694.
- [7] Stephens PC, Heimer R. Viral Load in Cervical, Vaginal, and Menstrual Fluids as Compared to Peripheral Blood levels in a Group of Women with HIV and AIDS. 2nd National Conference on Women and AIDS , Los Angeles, California. March 1997.
- [8] Hankins CA, Handley MA, HIV disease and AIDS in women: current knowledge and a research agenda. 1992. *Journal of Acquired Immunodeficiency Syndrome*, 5:957-971.
- [9] 1993 Revised Classification System for HIV Infection and expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, Centers for Disease Control and Prevention, *MMWR*, December 18, 1992 / 41(RR-17)
- [10] Culp TD, Budgeon LR, et al., "Keratinocyte-secreted laminin 5 can function as a transient receptor for human papillomaviruses by binding virions and transferring them to adjacent cells." *Journal of Virology*, 2006 September; 80(18):8940-50.

- [11] Nicol AF, Fernandez ATG, et al. Distribution of immune cell subsets and cytokine producing cells in the uterine cervix of human papillomavirus (HPV) infected women: Influence of HIV-1 co-infection. 2004. *Diagnostic Molecular Pathology* (in press).
 - [12] Quinlivan JA, Petersen RW, Davy M, and Evans SF. Abnormal pap smears in teenage mothers and the association with domestic violence, homelessness and Chlamydia. 2004. *Journal of Lower Genital Tract Disease*, 8(2):112-7.
 - [13] Lewis M, A Situational Analysis of Cervical Cancer: Latin America and the Caribbean, 2004. Pan American Health Organization (PAHO), Washington DC.
-

IMPORTANT NOTICE

FDA News
FOR IMMEDIATE RELEASE

P06-77

June 8, 2006

**FDA Licenses New Vaccine for Prevention of Cervical Cancer
and Other Diseases in Females Caused by Human Papillomavirus**

On the next two pages please find the FDA press release and the HPV Vaccine consumer information sheet. Both include contact numbers for further information.



FDA Home Page | Search FDA Site | FDA A-Z Index | Contact FDA | FDA Centennial

FDA News

FOR IMMEDIATE RELEASE

P06-77

June 8, 2006

Media Inquiries:

Julie Zawilska, 301-427-6242

Consumer Inquiries:

888-INFO-FDA

FDA Licenses New Vaccine for Prevention of Cervical Cancer and Other Diseases in Females Caused by Human Papillomavirus

Rapid Approval Marks Major Advancement in Public Health

The Food and Drug Administration (FDA) today announced the approval of Gardasil, the first vaccine developed to prevent cervical cancer, precancerous genital lesions and genital warts due to human papillomavirus (HPV) types 6, 11, 16 and 18. The vaccine is approved for use in females 9-26 years of age. Gardasil was evaluated and approved in six months under FDA's priority review process—a process for products with potential to provide significant health benefits.

"Today is an important day for public health and for women's health, and for our continued fight against serious life-threatening diseases like cervical cancer," said Alex Azar, Deputy Secretary, U.S. Department of Health and Human Services (HHS). "HHS is committed to advancing critical health measures such as the development of new and promising vaccines to protect and advance the health of all Americans."

HPV is the most common sexually-transmitted infection in the United States. The Centers for Disease Control and Prevention estimates that about 6.2 million Americans become infected with genital HPV each year and that over half of all sexually active men and women become infected at some time in their lives. On average, there are 9.710 new cases of cervical cancer and 3,700 deaths attributed to it in the United States each year. Worldwide, cervical cancer is the second most common cancer in women, and is estimated to cause over 470,000 new cases and 233,000 deaths each year.

For most women, the body's own defense system will clear the virus and infected women do not develop related health problems. However, some HPV types can cause abnormal cells on the lining of the cervix that years later can turn into cancer. Other HPV types can cause genital warts. The vaccine is effective against HPV types 16 and 18, which cause approximately 70 percent of cervical cancers and against HPV types 6 and 11, which cause approximately 90 percent of genital warts.

"This vaccine is a significant advance in the protection of women's health in that it strikes at the infections that are the root cause of many cervical cancers," said Andrew C. von Eschenbach, MD, Acting Commissioner of Food and Drugs. "The development of this vaccine is a product of extraordinary work by scientists as well as by FDA's review teams to help facilitate the development of very novel vaccines to address unmet medical needs. This work has resulted in the approval of a number of new products recently, including Gardasil, which address significant public health needs."

Gardasil is a recombinant vaccine (contains no live virus) that is given as three injections over a six-month period. Immunization with Gardasil is expected to prevent most cases of cervical cancer due to HPV types included in the vaccine. However, females are not protected if they have been infected with that HPV type(s) prior to vaccination, indicating the importance of immunization before potential exposure to the virus. Also, Gardasil does not protect against less common HPV types not included in the vaccine, thus routine and regular pap screening remain

<http://www.fda.gov/bbs/topics/NEWS/2006/NEW01385.html>

10/27/2006

<http://www.fda.gov/bbs/topics/NEWS/2006/NEW01385.html>

10/27/2006

critically important to detect precancerous changes in the cervix to allow treatment before cervical cancer develops.

"This is the first vaccine licensed specifically to prevent cervical cancer. Its rapid approval underscores FDA's commitment to help make safe and effective vaccines available as quickly as possible. Not only have vaccines dramatically reduced the toll of diseases in infants and children, like polio and measles, but they are playing an increasing role protecting and improving the lives of adolescents and adults," said Jesse Goodman, MD, MPH, Director of FDA's Center for Biologics Evaluation and Research.

Four studies, one in the United States and three multinational, were conducted in 21,000 women to show how well Gardasil worked in women between the ages of 16 and 26 by giving them either the vaccine or placebo. The results showed that in women who had not already been infected, Gardasil was nearly 100 percent effective in preventing precancerous cervical lesions, precancerous vaginal and vulvar lesions, and genital warts caused by infection with the HPV types against which the vaccine is directed. While the study period was not long enough for cervical cancer to develop, the prevention of these cervical precancerous lesions is believed highly likely to result in the prevention of those cancers.

The studies also evaluated whether the vaccine can protect women already infected with some HPV types included in the vaccine from developing diseases related to those viruses. The results show that the vaccine is only effective when given prior to infection.

Two studies were also performed to measure the immune response to the vaccine among younger females aged 9-15 years. Their immune response was as good as that found in 16-26 year olds, indicating that the vaccine should have similar effectiveness when used in the 9-15 year age group.

The safety of the vaccine was evaluated in approximately 11,000 individuals. Most adverse experiences in study participants who received Gardasil included mild or moderate local reactions, such as pain or tenderness at the site of injection.

The manufacturer has agreed to conduct several studies following licensure, including additional studies to further evaluate general safety and long-term effectiveness. The manufacturer will also monitor the pregnancy outcomes of women who receive Gardasil while unknowingly pregnant. Also, the manufacturer has an ongoing study to evaluate the safety and effectiveness of Gardasil in males.

Gardasil is manufactured by Merck & Co., Inc., of Whitehouse Station, NJ.

For more information, see:

- <http://www.fda.gov/cber/products/hpvmer060806.htm>
- <http://www.fda.gov/womens/getthefacts/hpv.html>

####

RSS Feed for [FDA News Releases](#) [what's this?]

Get free weekly updates about FDA press releases, recalls, speeches, testimony and more.

[Media Contacts](#) | [FDA News Page](#)

[FDA Home Page](#) | [Search FDA Site](#) | [FDA A-Z Index](#) | [Contact FDA](#) | [Privacy](#) | [Accessibility](#)

[FDA Website Management Staff](#)

Women's Health

Take Time To Care www.fda.gov/womens



HPV (human papillomavirus)

What is HPV?

HPV (human papillomavirus) is a sexually transmitted virus. It is passed on through genital contact (such as vaginal and anal sex). It is also passed on by skin-to-skin contact. At least 50% of people who have had sex will have HPV at some time in their lives.

Why haven't I heard of HPV?

HPV is not a new virus. But **many people don't know about it. Most people don't have any signs. HPV may go away on its own**—without causing any health problems.

Who can get HPV?

Anyone who has ever had genital contact with another person may have HPV. Both men and women may get it — and pass it on — without knowing it. Since there might not be any signs, a person may have HPV even if years have passed since he or she had sex.

What makes a person more likely to get HPV?

Most people who have sex may get HPV. You are more likely to get HPV if you have:

- sex at an early age,
- many sex partners, or
- a sex partner who has had many partners.

If there are no signs, why do I need to worry about HPV?

There are many kinds of HPV and not all of them cause health problems. Some kinds of HPV may cause problems like genital warts or cervical cancer. HPV types 16 and 18 cause about 70% of cervical cancers. HPV types 6 and 11 cause about 90% of genital warts.

Is there a cure for HPV?

There is no cure for the virus (HPV) itself. There are treatments for the health problems that HPV can cause, such as genital warts, cervical changes, and cervical cancer.

What should I know about genital warts?

There are many treatment choices for genital warts. But even after the warts are treated, the virus might still be there and may be passed on to others. If genital warts are not treated they may go away, stay the same, or increase in size or number, but they will not turn into cancer.

What should I know about cervical cancer?

All women should get regular Pap tests. The Pap test looks for cell changes caused by HPV. The test finds cell changes early — so the cervix can be treated before the cells turn into cancer. This test also can also find cancer in its early stages so it can be treated before it becomes too serious. It is rare to die from cervical cancer if the disease is caught early.

Is there a test for HPV?

Yes. It tests for the kinds of HPV that may lead to cervical cancer. The FDA approved the HPV test to be used for women over 30 years old. It may find HPV even before there are changes to the cervix. Women who have the HPV test still need to get the Pap test.

Can I lower my chances of getting HPV?

- You can choose not to have sex (abstinence).
- If you have sex, you can limit the number of partners you have.
- Choose a partner who has had no or few sex partners. The fewer partners your partner has had — the less likely he or she is to have HPV.
- It is not known how much condoms protect against HPV. Areas not covered by a condom can be exposed to the virus.

What is the HPV vaccine and how does it work?

The vaccine, called Gardasil, mimics the disease and creates resistance. It is **NOT** a live or a dead virus. It prevents infection with HPV types 6, 11, 16 and 18.

Is it safe?

Tests of the vaccine showed only minor problems. Some people had a slight fever. Others had redness or irritation on their skin where they got the shot.

Is it effective?

Gardasil is between 95-100% effective against HPV types 6, 11, 16, 18.

Who should get the HPV vaccine?

The FDA has approved Gardasil for girls and women ages 9-26. It is best to get the shot before the start of sexual activity.

How many shots do you need?

There are three shots. Once you get the first shot, you need a second shot two months later. You need to get a third shot six months after you get the first shot.

How long are you protected?

Since the vaccine is new, more studies need to be done. For example, the FDA does not know if you will need to have a booster after a couple of years.

Should I get the vaccine if I already have HPV?

The vaccine will not treat or cure HPV. It may help people who have one type of HPV from being infected with the other types. For example, if you have type 6, it may protect you from getting type 16.

Can I catch HPV from getting the vaccine?

No. The vaccine does not contain the HPV virus.

For more information:

www.fda.gov/cber
www.fda.gov/womens

Pregnancy-Related Data

One of the best sources of information on sexual risk in the heterosexual community of childbearing age is pregnancy-related data. Of course, not every woman of childbearing age is at risk of HIV infection. Rather, the importance is that pregnancy data is first, a marker of sexual contact and second, is consistently collected within most jurisdictions.

Pregnancy-related data is also key information for planning and deploying programs to reduce Mother-to-Child-Transmission (MTCT).

Vital Statistics Pregnancy-related Data

The data in the table on the following page can be used in various activities including but not limited to:

- All Births
 - Basic data and used to calculate birth and other population-based rates
- Mother's Age in Years
 - A marker of sexual activity among young women
- Out of Wedlock Births
 - A possible marker of single parent situations, especially among young women
- Month that Prenatal Care Began
 - A marker of general access to care
 - Key marker for prenatal HIV counseling, testing, and when indicated, treatment
- Mother's Education in Years
 - A very general indicator of the mother's ability to access information and gain pregnancy and childrearing skills

Reference:

2002 Annual Report, Vital Statistics, NYSDOH.

http://www.health.state.ny.us/nysdoh/vital_statistics/2002.htm

NYS Resident Live Birth Summary by Race/Ethnicity 2002¹

NYSDOH Vital Statistics -- 2002 Annual Report

Category	Total Number	Percent of Total	White	Percent Black	All Other Races ²	Hispanic (All Races)
All Births (Number)	250,806	100.0	179,491	49,186	21,022	54,469
Mother's Age (Yrs)						
10-14	288	0.1	0.1	0.3	0.0	0.2
15-17	5,867	2.3	2.0	4.3	0.6	4.1
18-19	12,505	5.0	4.6	7.9	1.7	7.6
20-24	50,636	20.2	19.4	24.9	16.0	28.0
25-29	62,815	25.1	24.5	24.3	31.3	26.3
30-34	69,987	27.9	29.3	21.3	32.1	20.7
35-39	39,123	15.6	16.3	13.5	15.0	10.7
40-44	8,868	3.5	3.6	3.3	3.2	2.3
45+	625	0.2	0.3	0.2	0.2	0.1
Out of Wedlock Births	89,726	36.0	29.8	65.9	18.4	59.7
Month Prenatal Care Began						
1-3	175,032	74.1	77.6	63.0	69.4	66.0
4-6	47,108	19.9	17.7	26.4	23.9	26.3
7-9	11,211	4.7	3.6	8.4	5.9	6.7
None	2,952	1.2	1.0	2.2	0.8	1.1
Mother's Education in Years						
Less than 12	48,148	19.4	17.9	24.5	19.9	40.2
12	74,648	30.1	28.3	36.7	28.9	30.9
13-15	54,344	21.9	21.9	24.6	15.6	18.1
16	35,611	14.3	15.7	7.8	18.2	5.4
17 and More	35,588	14.3	16.2	6.4	17.5	5.4

Data Notes: Not all columns will sum to 100% due to rounding
Race is reported here as White, Black, and All Other Races which includes Asian/Pacific Islander, Native American/Alaskan Native, 2+ Races, and Other/Unknown Race. Please see **Data Availability Notice** in this volume
Hispanic, in this table, is an overlapping category as it includes persons of all races to whom this ethnicity applies

Geographic Risk

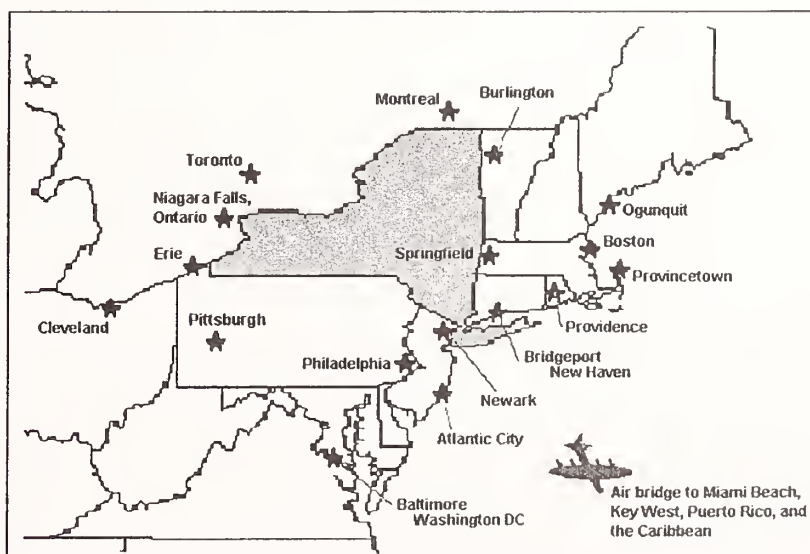
In the process of considering HIV prevention planning in rural vs. urban settings, the concept of geographical risk or geography-related risk evolved. This category of indirect risk includes but was not limited to:

- Risk related to travel for prevention, care, and services in NYS
- Risk related to locale of residence, employment, and or recreation in and out of NYS
- Risk related to gatherings and events in and out of NYS

For example, the April 21st, 2000, MMWR (Morbidity Mortality Weekly Report) included an article entitled: "HIV-related tuberculosis in a transgender network – Baltimore, Maryland and New York City area, 1998-2000." Four individuals were found to have the same TB DNA pattern which suggested that these individuals were, in some way, epidemiologically linked. Upon investigation of the outbreak, public health workers discovered that the individuals with TB were members of a social network that stretched from NYC to Baltimore and that the TB outbreak had occurred within that network.

Particularly during work on the issues of HIV in rural settings, anecdotal information revealed that, for example, many HIV+ men were most likely infected during relationships occurring in or related to travel outside NYS. The following map notes typical travel stops and/or destinations in the Northeast (and the Caribbean) for drug, sex, and recreation-related travel.

Out-of-State Risk



The following pages are maps taken from the National Drug Threat Assessment 2002, a document produced by the National Drug Intelligence Center and the El Paso Intelligence Center's Operation Pipeline. Substance use has long been recognized as occurring most heavily along routes of drug production and distribution.

Relatively new, however, is the emergence of the rural methamphetamine production lab. Running the lab in areas of low population decreases the risk of discovery due to the odors emitted. Conversely, the anonymity of the large urban center allows for unrecognized purchase of the chemicals needed for production. This has meant that new routes of distribution and use have developed tying previously ignored rural areas to historical drug transport routes.

References:

- [1] MMWR is available at <http://www.cdc.gov>

- [2] National Drug Threat Assessment 2002, a document produced by the National Drug Intelligence Center and the El Paso Intelligence Center's Operation Pipeline.
<http://www.usdoj.gov/ndic/pubs07/716/>

Drug Transportation Corridors

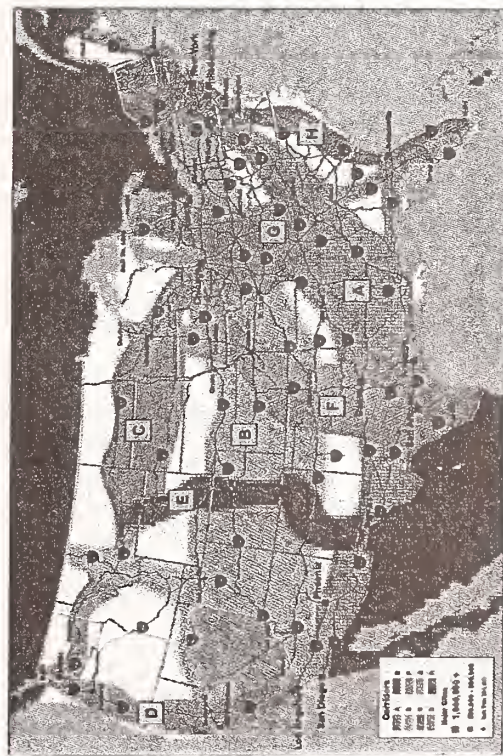


Figure 4. Drug corridors in the United States.

Virtually every interstate and highway in the United States is used by traffickers to transport illicit drugs to and from distribution centers and market areas throughout the country, and every highway intersection provides alternative routes to drug markets. However, analysis of current seizure data reveals eight principal corridors through which most illicit drugs and drug proceeds are transported to and from market areas (see Figure 4).

Corridor A, a west-east corridor, begins in southern California and extends through the Southwest, Southeast, and Northeast Regions. The southern branch of the corridor extends from Interstate 8 near San Diego (CA) to I-10 in central Arizona, which extends east and terminates in Jacksonville (FL). The northern branch of the corridor begins at I-10 near Los Angeles (CA), which connects with I-20 east of El Paso (TX), which connects with I-30 in Dallas (TX), which connects with I-40 in Little

Rock (AR), which connects with I-81 east of Knoxville (TN), which extends northeast and terminates north of Syracuse (NY).

Corridor B, a west-east corridor, begins in southern California and extends through the Southwest, Pacific, West Central, Great Lakes, and Northeast Regions. The primary routes along this corridor are Interstates 15, 40, 70, and 80. Interstate 15 extends from San Diego (CA) to the Montana-Canada border and intersects with I-40 in Barstow (CA), I-70 in west central Utah, and I-80 in Salt Lake City (UT). Interstate 40 intersects with I-44 in Oklahoma City (OK), which intersects with I-55 in St. Louis (MO), which terminates in Chicago (IL). Interstate 55 provides access to I-80/I-90 in Chicago (IL), which continues to the Northeast Region. Interstate 70 extends to the Northeast Region. Interstate 80 begins in the San Francisco (CA) Bay area, extends east, and terminates in New Jersey.

Corridor F, a south-north corridor, extends from the Texas-Mexico border through the West Central and Great Lakes Regions. The primary route along this corridor, I-35, extends from Laredo (TX) to Duluth (MN).

Corridor G, a south-north corridor, extends from South Florida to Detroit (MI) via I-75 and to Minneapolis (MN) via I-94. It is also a north-south corridor that extends from Sault Ste. Marie (MI) via I-75 into the Great Lakes Region.

Corridor H, an East Coast corridor, extends from Florida to Maine. The primary route along this corridor, I-95, extends from Miami (FL) to Houlton (ME).

Methamphetamine

Strategic Findings

- Decreased domestic methamphetamine production in both small- and large-scale laboratories—a result of law enforcement pressure, public awareness campaigns, and increased regulation of the sale and use of precursor and essential chemicals used in methamphetamine production—is reducing wholesale supplies of domestically produced methamphetamine.
- Decreases in domestic methamphetamine production have been offset by increased production in Mexico.
- Methamphetamine availability is not likely to decline in the near term, and in fact, Mexican DTOs can maintain production levels at laboratories in Mexico necessary to offset any further declines in domestic production, to ensure a steady supply of the drug in established markets, and to facilitate further eastward expansion of methamphetamine distribution.

Overview

Significantly decreased domestic methamphetamine production in both small- and large-scale laboratories—a result of increased law enforcement pressure, public awareness campaigns, and regulation on the sale and use of precursor and essential chemicals used in methamphetamine production, particularly pseudoephedrine—has decreased wholesale supplies of domestically produced methamphetamine. However, methamphetamine production in Mexico has increased to levels sufficient to offset domestic production decreases, to maintain distribution of the drug in established markets, and to facilitate further eastward expansion of the drug. Decreases in domestic production have resulted in a significant increase in the control that Mexican DTOs and criminal groups exert over domestic methamphetamine markets because individual users who previously relied on supplies produced in small-

scale domestic laboratories are increasingly forced to purchase the drug from Mexican methamphetamine distributors.

Availability

Methamphetamine availability is generally stable, with slight increases in eastern drug markets. National-level purity data reveal an overall rise in methamphetamine purity, indicating increased availability of the drug, although some of the increase most likely reflects an increased prevalence of more refined ice methamphetamine (typically much higher purity than powder methamphetamine) that is increasingly being produced by Mexican criminal groups for distribution in domestic markets. Seizure and arrest data are not as definitive as purity data. Methamphetamine-related arrests and seizures have recently decreased. This decrease, however, does not signify a decrease in availability, but a decrease in the level of domestic methamphetamine production. According to law enforcement officials, in previous years many methamphetamine-related arrests and seizures were the result of methamphetamine production investigations and laboratory seizures. As the level of domestic methamphetamine production has declined nationally, particularly since 2003, so has the number of methamphetamine arrests and seizures (see Appendix B, Tables 3 and 4).

While national-level data on methamphetamine availability is arguably inconclusive, anecdotal law enforcement reporting is unimpeachable and indicates relatively stable availability in long-established markets (particularly in the Pacific, Southwest, and West Central Regions) and increasing availability in the Great Lakes, Northeast, and Southeast Regions. The anecdotal reporting is supported by NDTs data that show that the percentage of state and local law enforcement agencies reporting high or moderate availability of methamphetamine is substantial (approximately 65%) and has been

stable nationally from 2003 through 2005 but has increased in the Great Lakes, Northeast, and Southeast Regions.

Methamphetamine availability will most likely increase in the near term, particularly in eastern states. Significant decreases in wholesale production in domestic laboratories have not reduced domestic availability of the drug; these reductions have been offset by methamphetamine produced by Mexican DTOs at laboratories in Mexico and transported to domestic markets via the U.S.–Mexico border. Moreover, intelligence reports indicate that Mexican DTOs most likely will be able to offset any further declines in domestic methamphetamine production by increasing production levels at laboratories in Mexico, which have not yet reached full capacity.

Production

Domestic methamphetamine production is decreasing; however, increased methamphetamine production by Mexican DTOs and criminal groups in Mexico—the principal foreign source of methamphetamine—appears to be sustaining or slightly increasing domestic wholesale supplies. National Clandestine Laboratory Seizure System (NCLSS) data show that the number of reported methamphetamine laboratory seizures decreased slightly from 2003 (10,199) to 2004 (9,895) (see Table 4). This decrease, the first reported decline since NCLSS became fully operational in 2000, is a strong indication of a real decrease in the number of operational domestic laboratories because it occurred even as nationwide participation in NCLSS—a voluntary reporting system for most state and local agencies—increased. Moreover, preliminary NCLSS data indicate a significant decrease in methamphetamine laboratory seizures in 2005. Decreased domestic methamphetamine production is further evidenced by NCLSS data that show a sharp decrease in seizures of methamphetamine superlabs—laboratories capable of producing at least 10 pounds of methamphetamine per production cycle—since 2001.

Increased restrictions on cold preparations and other medicines containing pseudoephedrine in

Table 4. Reported Methamphetamine Laboratory Seizures, 1997–2005

	Total Laboratories	Superlabs
1997	2,806	*
1998	3,802	*
1999	6,750	*
2000	7,021	*
2001	8,542	245
2002	9,282	142
2003	10,199	130
2004	9,895	55
2005**	5,249	37

Source: El Paso Intelligence Center National Clandestine Laboratory Seizure System.

*Laboratory capacity data were not collected prior to 2001.

**Data for 2005 are preliminary.

many states have contributed to sharp declines in the number of small-scale methamphetamine laboratories in those states. Similarly, restricted importation of bulk pseudoephedrine from Canada since January 2003 has resulted in significant declines in the number of domestic methamphetamine superlabs. More states are expected to enact precursor chemical control legislation; this will cause domestic methamphetamine production to further decline, particularly in small-scale laboratories.

Methamphetamine production by Mexican DTOs and criminal groups in Mexico has offset recent declines in domestic production, and the ability of these DTOs and criminal groups to offset further decreases in domestic production seems assured, according to intelligence reports. The increase in methamphetamine production in Mexico is dependent upon Mexican DTOs and criminal groups acquiring large quantities of pseudoephedrine or pseudoephedrine. Currently, they are reportedly obtaining these chemicals from criminal groups in Asia, who have been exporting massive quantities of pseudoephedrine and pseudoephedrine to Mexico since 2000, far exceeding the amount needed for legitimate use in the country.

Transportation

Transportation of methamphetamine from Mexico appears to be increasing, as evidenced by increasing seizures along the U.S.-Mexico border. The amount of methamphetamine seized at or between U.S.-Mexico border ports of entry (POEs) increased more than 75 percent overall from 2002 (1,129.8 kg), to 2003 (1,733.1 kg), and 2004 (1,984.6 kg).

The sharp increase in methamphetamine seizures at or between U.S.-Mexico border POEs most likely reflects increased methamphetamine production in Mexico since 2002. Mexican DTOs and criminal groups are the primary transporters of Mexico-produced methamphetamine to the United States. They use POEs

primarily in Arizona and southern Texas as entry points to smuggle methamphetamine into the country from Mexico. Previously, California POEs were the primary entry points used by these DTOs and criminal groups; however, increasing methamphetamine production in the interior of Mexico has resulted in Mexican DTOs and criminal groups shifting some smuggling routes eastward. Methamphetamine transportation from Mexico to the United States by these DTOs and criminal groups is likely to increase further in the near term as production in Mexico-based methamphetamine laboratories continues to increase in order to offset declines in domestic production.

Methamphetamine: Eastward Expansion

The trafficking and abuse of methamphetamine—a leading drug threat in western states since the early 1990s—have gradually expanded eastward, reaching the point where the drug now impacts every region of the country, although to a much lesser extent in the Northeast Region. In the early 1990s methamphetamine trafficking was an evident threat to California drug markets such as Fresno, Los Angeles, Sacramento, San Diego, and San Francisco. By the mid-1990s that threat had expanded to other drug markets, including Denver, Las Vegas, Phoenix, Seattle, and Yakima, Washington. By the late 1990s and early 2000s—as methamphetamine production and distribution remained very high in western states—methamphetamine trafficking continued its eastward expansion (see Appendix A, Map 4), supported by distribution by Mexican criminal groups and high levels of local production.

The eastward expansion of the drug took a particular toll on central states such as Arkansas, Illinois, Indiana, Iowa, Kansas, Missouri, and Nebraska. Increased methamphetamine trafficking in these states (see Appendix C, Chart 2), often in rural areas, is evidenced by a 126 percent increase (1,601 to 3,620) in reported methamphetamine laboratory seizures and an 87 percent increase (10,145 to 18,951) in methamphetamine-related treatment admissions from 1999 through 2003. Since 2003 methamphetamine trafficking has expanded farther east to areas such as southern Michigan, Ohio, and western Pennsylvania. The eastward expansion of methamphetamine trafficking and abuse has recently slowed because increasing regulation of the sale and use of chemicals used in methamphetamine production, particularly pseudoephedrine and ephedrine, has substantially decreased domestic production. However, Mexican DTOs and criminal groups have supplanted decreases in domestic production with methamphetamine that they are producing in Mexico. If they are successful, methamphetamine trafficking will spread farther eastward to encompass the entire United States.

Distribution

Mexican criminal groups control most wholesale distribution of powder and ice methamphetamine. According to DEA and HIDTA reporting, Mexican criminal groups are the predominant wholesale methamphetamine distributors in the country—even in the Northeast and Florida/Caribbean Regions—supplying various midlevel distributors, including other Mexican criminal groups, with powder methamphetamine and, increasingly, ice methamphetamine. Mexican control over wholesale and midlevel methamphetamine distribution is likely to increase as a greater proportion of wholesale methamphetamine production occurs in Mexico-based laboratories. Anticipated declines in domestic methamphetamine production, particularly by independent producers, will strengthen the position of Mexican criminal groups as midlevel and retail distributors, since more individual users who previously produced their own methamphetamine in small-scale laboratories will become increasingly dependent upon consistent supplies from Mexican methamphetamine distributors.

Although most national-level methamphetamine distribution centers are located in western states (see Appendix A, Map 6), the eastward expansion of methamphetamine has recently resulted in Atlanta's emergence as a principal distribution center for the drug. In fact, much of the methamphetamine distribution by Mexican criminal groups in the Southeast Region is now coordinated through Atlanta. Much of the midlevel and retail distribution of methamphetamine throughout the country is controlled by Mexican criminal groups and Hispanic street gangs; however, Caucasian independent dealers have been the predominant retail distributors, particularly in rural areas, where much of the drug is distributed and consumed. The predominance of Caucasian independent distributors at the retail level, however, will most likely diminish significantly as domestic production of methamphetamine wanes.

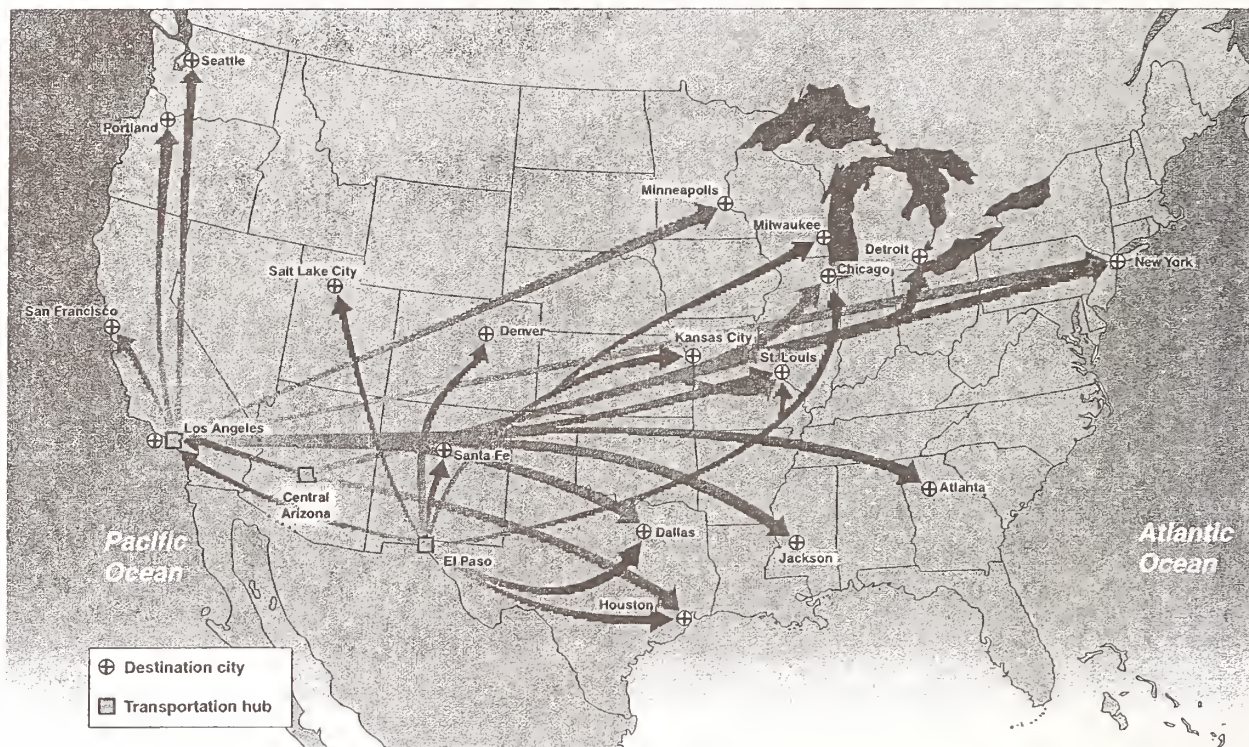
Demand

Overall methamphetamine use appears to be stable, at least among casual users. According to NSDUH data, rates of past year use for methamphetamine among individuals aged 12 and older have not shown any significant change over the last 3 years (see Appendix B, Table 1). Adults are the largest user cohort for methamphetamine, and NSDUH data show relatively stable rates of past year use for methamphetamine among both young adults (aged 18-25) and older adults (aged 26 and older).

Treatment Episode Data Set (TEDS) data show that the number of treatment admissions to publicly funded treatment facilities for methamphetamine has increased since the mid-1990s, most likely because of increased access to drug treatment and increases in treatment referrals from drug courts (see Appendix C, Chart 1). Also contributing to rising treatment admissions for methamphetamine is a very high recidivism rate among individuals seeking treatment for abuse of the drug. As a result, many methamphetamine users seek treatment several times before they successfully stop use of the drug.

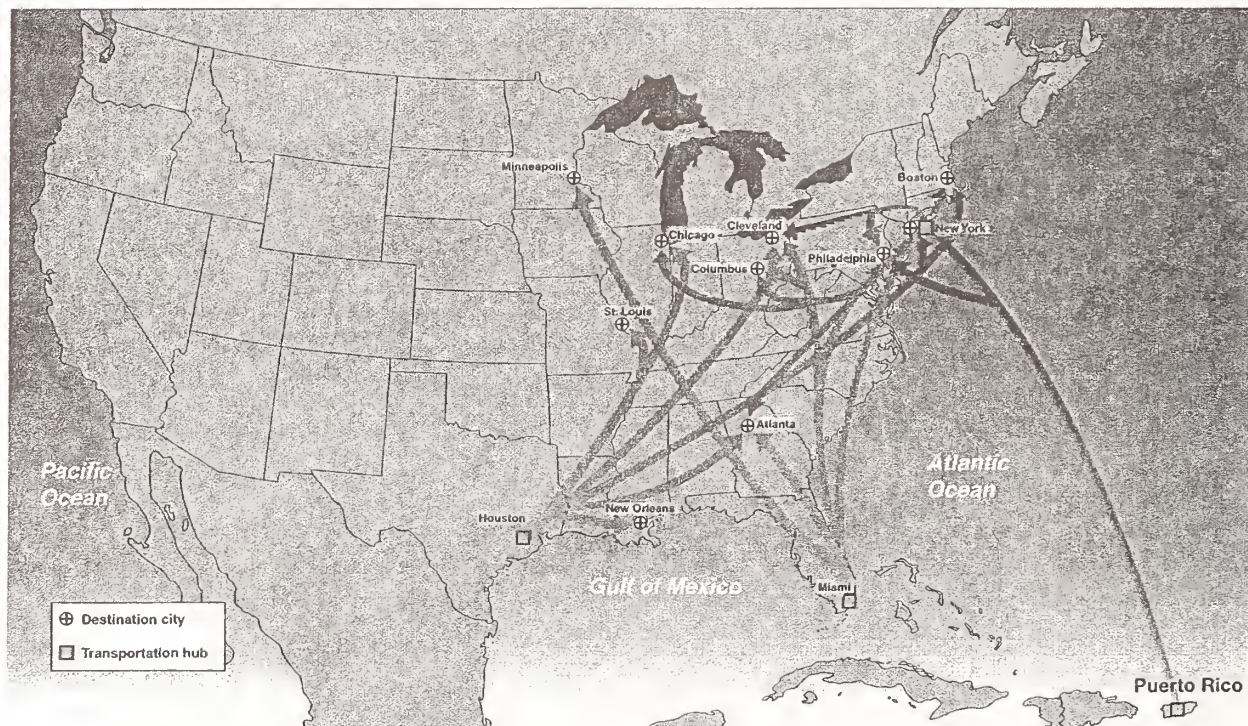
Although methamphetamine use among casual users appears stable, use among chronic users is not likely to decline in the near term. Despite sharp increases in the number of admissions to publicly funded treatment facilities for methamphetamine use, primarily in the West and Midwest, particularly since 2000, progress in reducing methamphetamine use among frequent users is slow because of the highly addictive nature of the drug and high recidivism rates for methamphetamine addicts pursuing treatment.

Map 2. Western Cocaine Transportation Hubs



Source: National Drug Intelligence Center, National Drug Threat Survey 2001, and El Paso Intelligence Center, Operation Pipeline (Convoy and Jetway).

Map 3. Eastern Cocaine Transportation Hubs



Source: National Drug Intelligence Center, National Drug Threat Survey 2001, and El Paso Intelligence Center, Operation Pipeline (Convoy and Jetway).

Distribution Centers

Traffickers transport heroin from transportation hubs to key distribution centers in the United States, cities from which the drug is distributed regionally and across the country. Analysis of federal, state, and local law enforcement reporting indicates that the transportation hubs of New York, Chicago, and Los Angeles also are distribution centers for a large portion of the heroin sold in the United States. Other cities identified as transportation hubs that also are used as distribution centers include Miami and Houston. In addition to these cities, Philadelphia is a significant heroin distribution center.

Map 10. Heroin Distribution from New York



Source: National Drug Intelligence Center, National Drug Threat Survey 2001.

New York. New York is the primary distribution center for South American heroin destined for markets throughout the country. On a smaller scale, traffickers use New York as a distribution hub for Southeast and Southwest Asian heroin, brokering deals in that city and distributing heroin throughout the state as well as to the New England, New York/New Jersey, Great Lakes, and Southeast regions. Agencies in Alabama, Connecticut, Delaware, Georgia, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Virginia, Washington, D.C., and Wisconsin identify New York City as a source for the heroin available in their areas. Investigative information also indicates that the city may serve as a transshipment point for limited quantities of South American heroin destined for Canada.

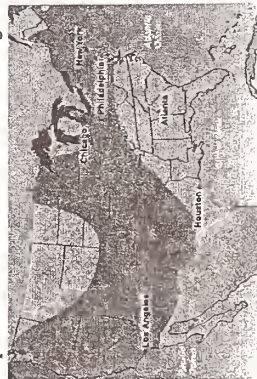
Map 11. Heroin Distribution from Chicago



Source: National Drug Intelligence Center, National Drug Threat Survey 2001.

Chicago. Traffickers use Chicago as a distribution center for heroin from all four source areas. Traffickers distribute heroin from Chicago throughout Illinois and to other states including Indiana, Iowa, Ohio, Minnesota, Missouri, and Wisconsin.

Map 12. Heroin Distribution from Los Angeles



Source: National Drug Intelligence Center, National Drug Threat Survey 2001.

Los Angeles. Los Angeles is a distribution center for Mexican heroin and, occasionally, a transshipment point for Southeast Asian and Southwest Asian heroin destined for other markets. Traffickers in Los Angeles distribute Mexican heroin to locations throughout California; to states including Arizona, Colorado, Hawaii, Illinois, Maryland, Minnesota, Missouri, Nevada, New Mexico, New York, Ohio, Oregon, Texas, Utah, and Washington; and to other areas west of the Mississippi River. South American heroin en route to the northeastern United States also may be transhipped through Los Angeles, according to seizure reporting.

Map 13. Heroin Distribution from Miami



Source: National Drug Intelligence Center, National Drug Threat Survey 2001.

Miami. Traffickers use Miami as a distribution center for South American heroin smuggled into the United States. South American heroin typically is smuggled into the country through Miami International Airport and is transported to northeastern cities, primarily New York, by bus, by rail, and on domestic flights. Agencies in Alabama, Colorado, Kentucky, Louisiana, Maryland, New York, North Carolina, and Tennessee identified Miami as the source for the heroin available in their areas.

Map 14. Heroin Distribution from Houston



Source: National Drug Intelligence Center, National Drug Threat Survey 2001.

Houston. Houston is a distribution center for heroin from Mexico and a transshipment point for heroin from the other source areas. Agencies in New York, Louisiana, Mississippi, Missouri, and Virginia identified Houston as the source of the heroin available in their areas. Agencies in Houston reported that heroin in the city is being shipped to other states including Illinois, Michigan, and Louisiana.

Commercial Sex Work

Commercial sex work involvement as either a worker or a consumer is a marker for risk of HIV acquisition. Commercial sex workers are regularly included among populations at risk of HIV/AIDS. Inclusion of commercial sex work under the heading of markers of risk is an attempt to broaden the discussion of sex work risk.

-- --

Commonly held assumptions dictate that only women are “prostitutes” and only males are “Johns” (customers). Further, it is believed that “prostitutes” spread disease, including HIV, to their male customers through sexual contact. These stereotypes are at odds with the reality of sex trade. In fact, risk is shared as follows:

- Individuals, women and men, involved in commercial sex work are at risk for HIV-infection through both their commercial and their personal behaviors. The behaviors may be sex- and/or drug-related. HIV-transmission risk for sex workers includes:
 - Street workers:
 - are typically at increased risk as compared to those who work indoors in brothels or escort services
 - are more likely to be poor, homeless, and/or dependent on drugs and alcohol
 - are less likely to be in control of their environment (e.g., in a customer’s car)
 - are less likely to control monetary transactions (e.g. price set for a sex act or percentage of fee the CSW is able to retain per sex act)
 - are less likely to or able to insist on condom use
 - are more likely to accept increased payment to *not* use safer sex, i.e. condoms, and/or be subject to violence for requesting/insisting on condom use
- The highest levels of HIV seroprevalence are among those who have unprotected anal intercourse (UAI) with their non-paying partners
- Seroprevalence may also depend on personal/partner/client injection drug use and on geography
- Female IDUs who exchange sex for drugs are more likely to share syringes than are female IDUs who do not engage in sex trading
- Non-injected drug use increases the likelihood of both sex work and unsafe sex; a recent study reported that among regular crack smokers, 68% exchanged sex for drugs or money

- HIV infection has been associated with heavy crack use, methamphetamine use, and unprotected fellatio in association with poor oral health/hygiene; oral damage due to crack pipe use, increased fellatio, and inconsistent condom use may contribute to this association
- The commercial sex worker, male or female, may be under the control of a pimp, a brothel owner, or other “manager” and may be more likely to experience violence with personal and commercial partners [1]
- Relationship/Steady partners of commercial sex workers may be at risk of HIV infection due to:
 - Personal sexual behavior outside the partnership/relationship with the commercial sex worker
 - Personal drug and/or alcohol behaviors
- Customers/Clients may be at risk of HIV infection due to:
 - Personal sexual behavior outside the partnership/relationship with the commercial sex worker
 - Personal drug and/or alcohol behaviors
- Children of commercial sex workers may be at risk of perinatal HIV transmission if a parent or parents are HIV-infected

Resources

[1] What are Sex Workers' HIV Prevention Needs? Center for AIDS Prevention Studies, University of California–San Francisco. <http://www.caps.ucsf.edu/prosttext.html>

what are sex workers' HIV prevention needs?

are sex workers at risk for HIV?

It depends on who they are and how they work. The people who are most vulnerable to HIV infection are street workers, most of whom are poor or homeless, and many of whom are young, have a history of childhood abuse and are likely to be drug or alcohol dependent. Street prostitutes are extremely vulnerable to violence from clients, police, and sometimes their lovers. Male and female sex workers who work off the street (in brothels, massage parlors, their own apartments, or escort services) are much less likely to become infected, largely because they are less likely to depend on drugs or alcohol and more likely to be able to control the sexual transaction and insist on condoms.¹

A study of 1,396 female sex workers in six US cities found an HIV seroprevalence of 12%, ranging from 0-47.5% depending on the city and the level of injecting drug use.² A study of 235 male street sex workers in Atlanta, GA, found 29.4% seroprevalence, with highest rates among those who had receptive anal sex with nonpaying partners.³

what puts sex workers at risk?

Injection drug use was the main risk factor for HIV infection for female prostitutes in six US cities.² Female injection drug users who trade sex for money or drugs are more likely to share needles than female injectors who do not engage in sex trading, and are less likely to use new needles or to clean old ones.⁴

Drug use can increase both the likelihood of sex work and unsafe sex. A study of crack cocaine users recruited from the streets in three urban neighborhoods found that 68% of women who were regular crack smokers had exchanged sex for drugs or money. Of those, 30% had not used a condom in the past 30 days.⁵

Recently, observers have found an association between HIV infection and heavy crack use and unprotected fellatio. This may be due to poor oral hygiene and damage to the mouth from crack pipes, high frequency of fellatio, and inconsistent condom use.⁶

Sex workers may agree to unprotected sex if a client offers substantially more money, if they are desperate for money to buy drugs, or if business has been slow. In some cases, clients may use violence to enforce unsafe sex. Police in many cities routinely confiscate condoms when they arrest or stop prostitutes, and prostitutes may not be able to obtain more condoms immediately. Thus, in some situations, sex workers are powerless to insist on condoms for safer sex.

Like many people in committed relationships, sex workers may find it difficult to discuss condoms or safer sex practices with their partner at home. In one study, although 94% of sex workers used condoms at some point with their clients, only 25% had used condoms with their partners at home.⁷

what are barriers to prevention?

The illegality of prostitution in the US drives the industry underground and engenders a strong distrust of both police and public health authorities among sex workers. This makes effective HIV prevention outreach difficult. Also, in many areas, possession of condoms is used as evidence of prostitution and therefore can be grounds for arrest for street-based and off-street sex workers.⁸

Desperation and lack of resources can override prevention concerns. Drug-addicted people may turn to prostitution to earn money to pay for the high cost of illegal drugs. Many homeless youth have no training or means of support, and rely on prostitution for survival. Attention to the more immediate concerns of food, housing and addiction often takes priority over future concerns of HIV infection.

Says who?

1. Alexander P. Sex work, AIDS, and the law. Testimony before the National Commission on AIDS; 1992.

2. Centers for Disease Control and Prevention. Antibody to human immunodeficiency virus in female prostitutes. *Morbidity and Mortality Weekly Report*. 1987;36:157-161.

3. Elifson KW, Boles J, Sweat M. Risk factors associated with HIV infection among male prostitutes. *American Journal of Public Health*. 1993;83:79-83.

4. Kail BL, Watson DD, Ray S. Needle using practices within the sex industry. *American Journal of Drug and Alcohol Abuse*. 1995;21:241-255.

5. Edlin BR, Irwin KL, Faruque S, et al. Intersecting epidemics: crack cocaine use and HIV infection among inner-city young adults. *New England Journal of Medicine*. 1994; 331:1422-1427.

6. Wallace JI, Weiner A, Bloch D et al. Fellatio is a significant risk activity for acquiring AIDS in New York City street walking sex workers. Presented at the Eleventh International Conference on AIDS, Vancouver BC; 1996.

7. Dorfman LE, Derish PE, Cohen JB. Hey Girlfriend: an evaluation of AIDS prevention among women in the sex industry. *Health Education Quarterly*. 1992;19:25-40. Contact: CAL-PEP 510/874-7850.

8. Cohen JB, Coyle SL. Interventions for female prostitutes. In HG Miller, CF Turner, LE Moses, eds. *AIDS The Second Decade*. Washington, DC: National Academy Press;1990.

what's being done?

Some rural counties in Nevada have legal prostitution governed by the state Board of Health. The Board requires that condoms be used for all acts of sex and that sex workers must be licensed and undergo weekly STD tests and monthly HIV tests, at their own expense.⁹ As of 1993, no women tested positive out of a total of 20,000 HIV tests of sex workers.¹⁰ Licensed prostitutes receive no sick leave or health insurance, and if they tested HIV-positive would be terminated without counseling or assistance.⁹

The California Prostitutes' Education Project (CAL-PEP) provides condoms, STD/HIV testing, AIDS education and drug treatment referral through regular and repeated street outreach. Outreach workers are former prostitutes who are trained in AIDS prevention. The project successfully encouraged prostitutes to use condoms regularly on the job, but found it difficult to influence condom use in private relationships.⁷

On the Streets Mobile Unit-Options in New York City, NY, runs vans that bring over 4,000 street prostitutes friendship, food, clothes, condoms, HIV/STD testing and counseling and needle exchange. They also help prostitutes get public assistance and/or drug treatment. Rates of HIV infection among clients have declined since 1989.¹¹

The Threshold Project in Seattle, WA, helps homeless youth acquire the skills necessary to live independently without sex work. Most of the clients in this program had been emotionally, physically, or sexually abused. The two-year program offered a series of progressively more independent living experiences, and in follow-up, 42% of participants remained in stable living situations without sex work.¹²

When free methadone maintenance was offered to heroin-addicted street prostitutes in southern California, most enrolled. After one year, personal income from prostitution and other crime was reduced 58% and income from legal sources increased 86%.¹³

Internationally, many HIV prevention efforts aimed at sex workers have addressed structural and policy considerations. In Thailand, the Ministry of Public Health began a 100% condom-use program in all sex establishments in several provinces. After the intervention in Samut Sakhon province, the number of condoms used increased from 15,000 to 50,000 a month, and STD incidence decreased from 13% to 0.3-0.5%.¹⁴

In Bulawayo, Zimbabwe, a multiplicity of approaches reached sex workers and clients. AIDS training targeted nurses and health care professionals, as well as non-conventional audiences such as hotel and bar workers and taxi drivers. Community outreach relied on sex worker and client peer educators and provided widespread condom distribution. STD services in the city were also strengthened.¹⁵

what still needs to be done?

In the US, HIV research among prostitutes has focused largely on their role as vectors of infection for the general public. To prevent HIV infection among prostitutes, it is essential to address the context in which sex work is transacted, as well as the specific practices of the prostitutes. Placing the major burden for HIV prevention on prostitutes themselves may not be most effective tactic. Economic dependence and gender power imbalances can make it nearly impossible for prostitutes to demand safer sex. Laws and police attitudes towards carrying condoms must be eased to allow sex workers to protect themselves. Decriminalizing prostitution and regulating sex businesses would remove many obstacles to consistent condom use and safer sex.¹⁶ Clients and brothel/escort service owners also need to be more actively targeted in prevention programs.

Increased funding is needed for prevention programs that address the full range of problems sex workers face, both on and off the streets, especially programs staffed and managed by peers. Drug treatment, housing, child care and skills training for prostitutes are essential. Better health care services are needed for prostitutes, including diagnosis and treatment for STDs/HIV, care for injuries due to violence, and mental health care. A comprehensive HIV prevention strategy uses a variety of elements to protect as many people at risk as possible. Sex workers require a broad range of protective services, including HIV prevention.

PREPARED BY PAMELA DECARLO, PRISCILLA ALEXANDER, HENRY HSU

9. Campbell CA. Prostitution, AIDS, and preventive health behavior. *Social Science and Medicine*. 1991;32:1367-1378. Contact: Lynnette Kappes, Nevada State Health Division, 702/687-4800.

10. Albert AE, Warner DL, Hatcher RA, et al. Condom use among female commercial sex workers in Nevada's legal brothels. *American Journal of Public Health*. 1995;85:1514-1520.

11. Whitmore R, Wallace JI, Weiner A, et al. HIV testing rates in New York City street walkers have declined. Presented at the Eleventh International Conference on AIDS, Vancouver, BC; 1996. Contact: Joyce Wallace 212/924-3733.

12. Schram DD, Giovengo MA. Evaluation of Threshold: an independent living program for homeless adolescents. *Journal of Adolescent Health*. 1991;12:567-572. Contact: Melinda Giovengo 206/282-1288.

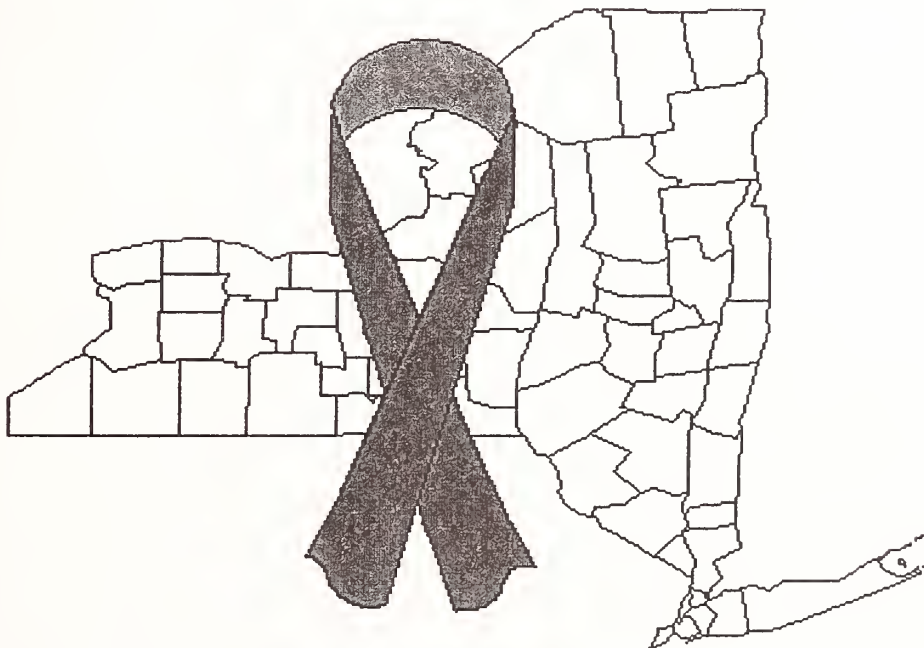
13. Bellis DJ. Reduction of AIDS risk among 41 heroin addicted female street prostitutes: effects of free methadone maintenance. *Journal of Addictive Diseases*. 1993;12:7-23. Contact: David Bellis 909/880-5759.

14. World Health Organization, Global Programme on AIDS. *Effective approaches to AIDS prevention*. Report of a meeting, Geneva, Switzerland, May 1992.

15. Lamptey P. An overview of AIDS interventions in high risk groups: commercial sex workers and their clients. In LC Chen, et al, eds. *AIDS and Women's Reproductive Health*. New York: Plenum Press;1991. Contact: AIDSCAP 703/516-9779

16. Leonard Z, Thistlethwaite P. Prostitution and HIV infection. In C Chris, M Pearl, eds. *Women, AIDS, and Activism*. Boston, MA: South End Press;1990.

Appendices



Abbreviations and Acronyms

African American	A subpopulation of Black; persons self-identifying or identified as Black and whose older relatives have lived in the US or the Americas for a number of generations
A/PI or API	Asian and Pacific Islander
Black	Persons self-identifying or identified as Black
Bld or Blood	Blood / Blood-related HIV transmission / Blood Products
CDC	Centers for Disease Control and Prevention
Het	Heterosexual
Hispanic	Person of Hispanic descent/ethnicity
ICE	Bureau of Immigration and Citizenship Enforcement, Department of Homeland Security
IDU	Injection Drug Use
Latino	Person of Latino descent/ethnicity
Low/Mid Hudson	Lower and Mid Hudson Ryan White Regions
Mom HIV/AIDS	Mother of the pediatric case has HIV/AIDS
Mom IDU	Mother of the pediatric case is an injection drug user (IDU)
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men and who also Inject Drugs
Multi Race	An individual of 2 or more races (2+ Races)
Nas/Sulf or N/S	Nassau/Suffolk Ryan White Region
NA/AN	Native American/Alaskan Native
Native Am.	Native American/Alaskan Native
NIR	No Identified Risk
NRR	No Risk Reported
NYC	New York City
NYS	New York State
Oth	Other
Peds or PED	Pediatric / Pediatric HIV Transmission
PI	Pacific Islander
ROS	Rest of State (same as Upstate)
RWR	Ryan White Region
Tot	Total
Undet	Undetermined
Unk	Unknown
Upstate	New York State excluding New York City (NYS-NYC or NYS excluding NYC)
US Census	United States Census Bureau



Key Data Sources

US Bureau of the Census

<http://www.census.gov/>

Centers for Disease Control and Prevention

<http://www.cdc.gov/>

European Surveillance Center

<http://www.eurosurveillance.org/index-02.asp>

UNIFEM - WHO site for women's health and gender equality

http://www.unifem.org/resources/item_detail.php?ProductID=39

Health Resources Service Administration – Ryan White Care Act and funding

<http://www.hrsa.gov/default.htm>

International AIDS Society – AIDS conferences, papers, issues

<http://www.iasociety.org/index.asp?>

Kaiser Family Foundation

<http://www.kff.org>

How to Read an Epidemiologic or Scientific Article

A Study Guide

Originally produced for the
NYS HIV Prevention Planning Group

Study Guide

- **Questions to ask yourself before you start reading:**
 - **What kind of article is this?**
 - Popular or lay magazine or newspaper
 - Scholastic or scientific journal
 - A chapter in a book
 - A government publication
 - A publication from a particular organization
 - From the Internet or other similar sources

2

- Is there an author or authors listed?
 - Have you heard of the author(s) before
 - What is the author(s)' background or expertise and/or where do they currently work
 - Does the background or expertise of the author(s) "fit" the topic of the article
- What is the publication date of the article?
 - Have there been new developments in the field which might support or negate the information in this article

3

- Now read the article
 - Mark any sections that are important to you or that you do not understand and want to come back to later
- After reading the article, ask yourself the following questions:
 - Was the article a study, an opinion paper/editorial, or a review of a group of other papers
 - For studies ask:
 - What was the size of the study (small, medium, large)
 - Where did the study take place
 - What kind of study was it (observation, survey, experimental, laboratory)
 - How were people recruited or samples obtained

4

- Does the “story” told about the study make sense to you even if you did not recognize all the scientific or statistical terms
- Was the outcome, conclusion, and/or discussion clear
- For opinion or editorial-type articles
 - Was the article even-handed, showing the weaknesses and strengths of all sides of the issue or situation
 - If supporting a specific viewpoint, were the arguments clear and fair

5

- For a review of a topic or field using information from a variety of other articles
 - Did the range of articles and the way in which they were selected make sense
 - Did the review address any differences in outcome among the articles
 - Did the conclusion reached make sense to you

- **Final Questions to ask yourself**

- Is there anyone who might also benefit from reading this article?
- Who might you get to help you to better understand unclear sections or to determine the importance of a particular section?
- How might this information affect or change your work or your thinking?
- Is there anything you should do differently now that you have this new information?

- **List here any questions you want to ask about the article:**

A graphic of a spiral-bound notebook with a grey cover and a white page. The spiral binding is on the left side. The text is centered on the page.

Contact Information

P. Clay Stephens
Division of HIV Prevention
AIDS Institute – NYSDOH
518-473-8484
pcs02@health.state.ny.us

How to Read and Use Epidemiologic Data

**Originally Prepared for the NYS HIV Prevention Planning Group
by the Bureau of HIV/AIDS Epidemiology, NYSDOH
March 2004**

Purpose

- **The Centers for Disease Control and Prevention Guidance for community planning states that all decisions must be grounded in and based upon an understanding of the HIV/AIDS epidemic as it exists within the group's jurisdiction.**
- **This manual is presented to assist in building that understanding**

How to Read Charts, Graphs, and Tables

- **First Step:**

- **Look at the chart as if you are looking at a drawing or photograph**
 - Is it clearly printed?
 - Is it large enough for you to see details well?
 - Can you see the edges and tell where the graph starts and ends?
 - Is there more than one chart, graph, or table within the edges?

How to Read 2

- **Second Step:**

- What kind of chart is it?
- What is the title?
- What is the legend and the scale on the vertical axis?
- What is the legend and the scale on the horizontal axis?
- Now study the data contained in the graph

How to Read 3

- **Third Step:**

After looking at the data ask yourself the following questions:

- When comparing one chart to another:
Are the units the same?
- What information does the chart give you?
 - Does it make sense?

How to Read 4

- **Fourth Step:**

Things to check for

- Is the data source given on the chart or in a footnote?
- Is there a date or time period given for the data?
- Does the title match the data?
- Are all parts labeled?

How to Read ... 5

- Remember.....

All these steps and chart parts may look complicated and hard to use but...

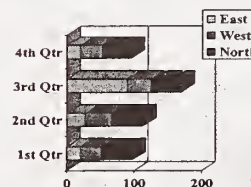
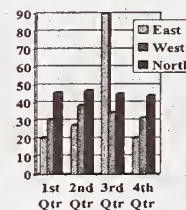
We all see and use charts and graphs all the time. These steps are simply a way to break down the process of looking at data so that each step is separate. Over time the separate steps become automatic. That's when data use turns from work to pleasure!

What Type of Chart or Graph is it?

- Bar Chart

In this style of chart the bars can be ...

- Vertical (standing up)
- Horizontal (laying down)
- Stacked
- Side-by-side
- Flat
- 3-D

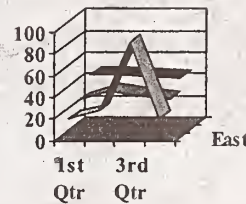
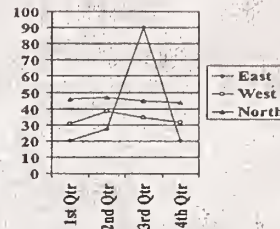


Types 2

▪ Line Graph

In this style of graph the lines can be ...

- Single or multiple
- Smooth
- Choppy
- Flat or broad lines
- With or without marks at each data point

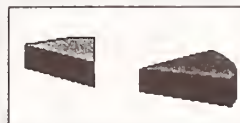
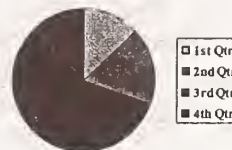


Types 3

▪ Pie Chart

In this style of graph the pie or its "slices" can be ...

- Flat
- 3-D
- A whole "pie"
- An "exploded" pie (the pieces do not touch each other)
- Only one or a few slices



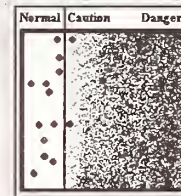
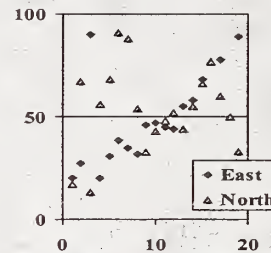
Types ... 4

Scatter Graph

In this style of graph the data points can be

...

- Connected by a line or separate points
- There may or may not be a pattern
- Lines/colors may be added to show differences between groups of points



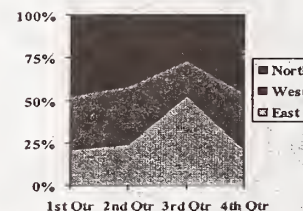
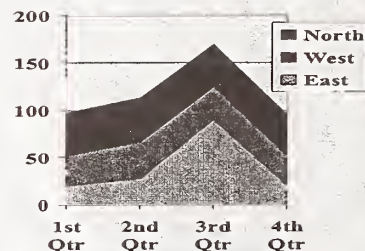
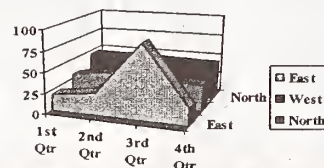
Types ... 5

Area Chart

In this style of graph the data points can be

...

- Stacked
- Area proportion
- Overlapping ▼



Types 6

▪ Mixed

There are many charts or graphs that mix styles in order to compare types of data. They can have one value scale (upper right chart) or two scales, one on either side of the chart (lower right chart)

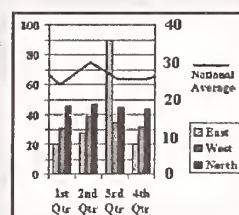
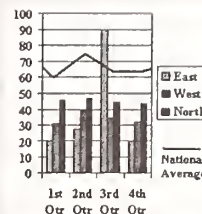
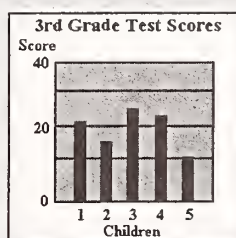
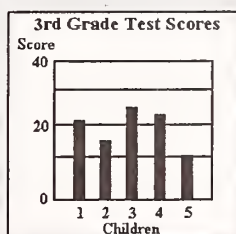
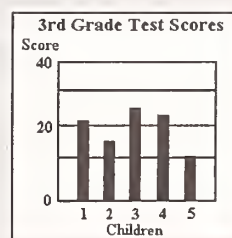


Chart Parts



Plot Area

Chart Title



Data Bars

Legends

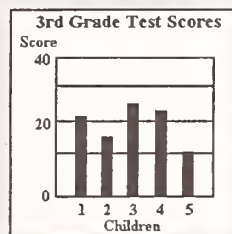
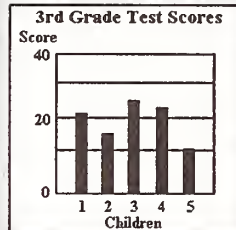
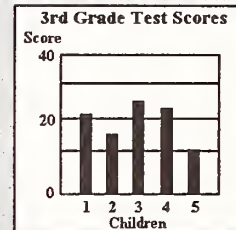


Chart Parts 2



Vertical axis or side arm and scale

Horizontal or lower arm and scale. An arm is also called an AXIS



- [1] It is VERY important to always check the legends on a chart in order to know what is being displayed
- [2] When comparing one chart to another, always check the maximum value on the vertical axis. The bars may be the same size on the paper or slide but one bar is 400 units high and the other is only 50 units high. Then check the scale of the horizontal axis as it may vary as well

A Reminder about Titles

- Read titles carefully; only one or two words can make a real difference
 - Example:
 - Title #1:
Persons [Presumed to be] Living with AIDS in the Buffalo Ryan White Region – 2002
 - Title #2:
Persons [Presumed to be] Living with HIV in the Binghamton Ryan White Region – 2003
 - What differences can you find? (Answers on the next slide)

Answer: 3 differences

- **Examples:**
 - **Title #1:**
Persons [Presumed to be] Living with AIDS in the Buffalo Ryan White Region – 2002
 - **Title #2:**
Persons [Presumed to be] Living with HIV in the Binghamton Ryan White Region – 2003
- **One:** Buffalo vs. Binghamton
- **Two:** AIDS vs. HIV
- **Three:** 2002 vs. 2003

Having a Problem Understanding a Chart or Graph?

- **Think of graphs as ‘stories’ about a particular group or population**
- **The graph should include enough information for the user to be able to answer these questions:**
 - **Who** (is being described? Who are the authors?)
 - **What** (is happening?)
 - **Where** (Is this information about a particular place?)
 - **When** (Is this information about a particular time?)
 - **How** (is this information gathered? displayed?)
 - **Why** (is this information important? Why is it useful?)

Problems ... 2

- It is often helpful to “re-graph” or “re-chart” the data as an exercise to help in understanding the material
- This can be done relatively easily with pencil and paper
- As the chart is reproduced, the ‘story’ it tells becomes more obvious as each part answers one or more of the questions asked on the previous slide

Homework:

- Should you decide to accept this assignment ...
 - The following are data and details of a simple bar graph. Use this information to draw the bar chart on the template (next slide). Compare your drawing to the completed chart on the last slide

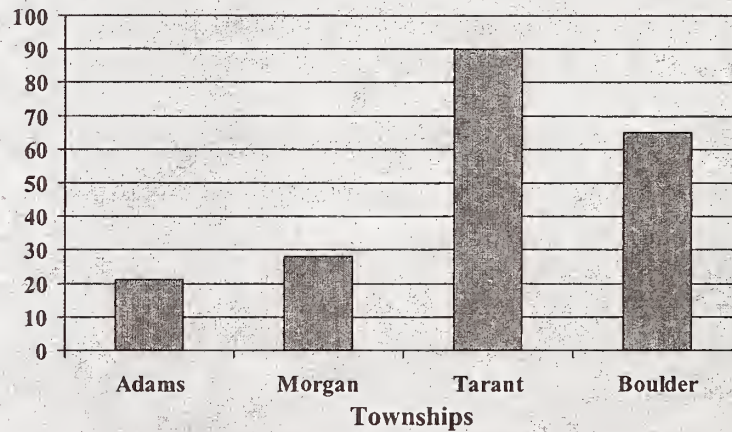
Chart Parts and Data

- Townships
- Adams, Morgan, Tarant, and Boulder are on the horizontal axis:
 - Adams = 21
 - Morgan = 28
 - Tarant = 90
 - Boulder = 65
- Scale on the vertical axis:
 - Maximum is 100; minimum is zero
- Title: Ventura County Adult STD Cases by Township – Calendar Year 1999



Ventura County Adult STD Cases by Township – Calendar Year 1999

Number of STD Cases



Contact Information

(Updated)

P. Clay Stephens

**Division of HIV Prevention – AIDS Institute
NYSDOH**

[518] 473-8484

pcs02@health.state.ny.us

Contact and Ordering Information



**Division of HIV Prevention
AIDS Institute
NYSDOH**

To order copies:

**Community Coordination Planning Section
518-473-8484 (Phone)
518-474-1199 (Fax)**

For comments, suggestions, or corrections:

**P. Clay Stephens
Division of HIV Prevention
518-473-8484 (Phone)
518-474-1199 (Fax)**







